MAY 1957

DUTIES AND PROBLEMS OF A
STATE COMMISSIONER OF MENTAL HEALTH

EXPERIMENTAL MANAGEMENT OF
A CHRONIC WARD

THE EMPLOYEES' RESPONSIBILITY
IN A FIRE PROTECTION PROGRAM

SOCIOPETAL BUILDING
AROUSES CONTROVERSY

Mental Hospitals

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THIS MONTH'S COVER

The lovely garden pictured on the cover (see also p. 18) is the handiwork of the horticultural therapy program which was established in 1948 at Friends Hospital. (The hospital's gardens had been developed over a period of more than one hundred years and offered an excellent physical setting for this activity.) When the program first started, some 35 patients a month took part; currently there are approximately 110 patients—the majority of the average daily census of 165—participating in the garden and greenhouse sessions.

As with other rehabilitation programs at Friends Hospital, horticultural therapy is geared to the needs of each patient. The program is directed by Miss Helen M. Foster and her assistant, Miss Jo Davis; both are graduates of the Pennsylvania School of Horticulture and were trained as therapists by the hospital staff. They attend medical staff meetings in order to get some idea of each new patient's illness and of the treatment recommendations. When a patient is first introduced to gardening, one of the therapists usually works alone with him until some sort of understanding is established between them. As Miss Foster puts it, "By working with the patient individually for a while, particularly the one who doesn't feel he's interested in gardening, we can usually see a small spark of interest and often can lead him into very active participation in the program."

Gardening is prescribed for the patients by their physician, and attendance varies from twice a day to once a week. The very confused or apathetic patient is given a gross activity, such as raking leaves or hoeing, while the earnest, meticulous patient may work with small seedlings. It is interesting to note that nearly all tense patients relax considerably as soon as they are working in the soil. There has been no assaultive behavior during the gardening sessions.

There is a wide variety of gardening activities available on the hospital's 100 acres, with its seven gardens and three greenhouses. The all-purpose garden pictured on the cover, for instance, is arranged in triangles which permit patients to work individually or in groups. Being enclosed, it is easily supervised and its plantings of annuals, perennials, bulbs and boxwood offer year-round occupation.

Recently an indoor program was begun for elderly patients who cannot get outdoors. Weekly sessions lasting from 30 to 45 minutes, depending on the interest span of the participants, feature such activities as making terrariums, growing seeds in plastic trays and small plants in eggshells, and making sachets from rose petals and lavender.

Horticultural therapy seems to hold certain advantages over other forms of occupational activities. Almost any degree of muscular coordination and of mental concentration can be used. The patient can proceed at his own pace without any competitive pressure from others. Nature does not penalize him sharply for his errors and there is no need for exactitude or great skill. He works in the pleasantest of surroundings, whether indoors or out, and can look forward to a variety of new experiences daily throughout the year. And he can learn an inexpensive and fascinating hobby that he may enjoy throughout his life. More than one patient, in fact, has gone on from the garden work at Friends to become a graduate of a horticulture school.

THEODORE L. DEHNE, M.D., Supt.
Friends Hospital, Philadelphia, Pa.

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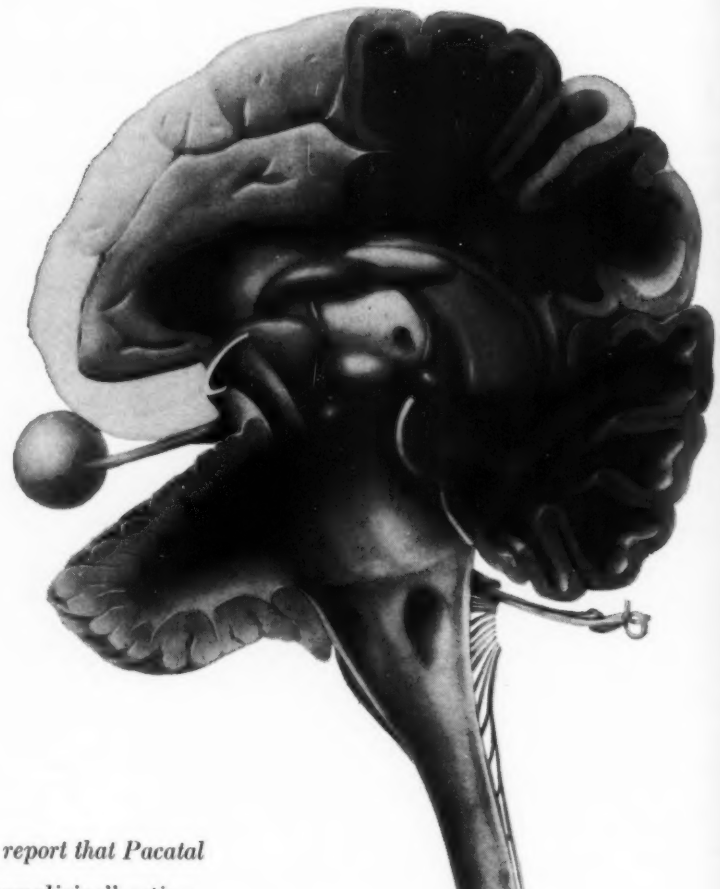

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THE DUTIES AND PROBLEMS OF A STATE COMMISSIONER OF MENTAL HEALTH

By PAUL H. HOCH, M. D.

Commissioner of Mental Hygiene, State of New York;
Professor of Clinical Psychiatry, College of Physicians and Surgeons, Columbia University

IN SOME STATES the Commissioner of Mental Health is in charge of a department responsible for all mental health activities maintained by the state. In others no such department exists, but either there is a board to whom a commissioner is responsible for administrative functions, or the state department of health has a sub-division for mental health which performs the same tasks. In yet other states the department of welfare is in charge of the same problems, and in some states all the state institutions—correctional, health, mental health, etc.—are organized into one department. Obviously, within such varying frameworks, various administrative formulae can be applied to the problems of mental health on a state level. We feel strongly, however, about one point: that only the department of mental health, or a division of mental health in states not large enough to have a special department, can be the basis of effective mental health administration. Mental health has become such a major area that it cannot be subordinated to health or welfare without having the framework of a special organization which will give full attention to mental health problems and needs.

Psychiatry, on which all mental health approaches rest, is a medical discipline which has to face many problems in common with departments of health. Many of the problems occuring in mental health today also affect general health administration. As an example, there is the great problem of the aged whose arteriosclerotic and senile disturbances concern both the general health department and the department of mental health. Many of these problems can be and should be tackled in close cooperation. But if psychiatric complications are also present, the physical, social, and rehabilitative aspects even of these disorders will have to rest with the department which is basically psychiatric in orientation. The aged with psychiatric afflictions need coordinated efforts for their welfare which go far beyond the physical health aspects of the problem.

It is very important to mention that the department of mental health is not only a policy-making or an investigative body. It is usually the center of an administrative organization which operates a number of hospitals, state schools, clinics, and so on. The general departments of health are in some ways in a favorable position because they are able to concern themselves mainly with broad policy measures, with research, and with stimulating and coordinating health activities in the state, without being too involved with service functions on an administrative level. Most of the hospitals, probably with the exception of the tubercular and other specialized ones, are run by private or municipal agencies. The district health offices and laboratories are maintained by counties and cities.

In contrast, the mental health departments are usually administrative centers for the state hospital organization and much of their time is taken in administering the state hospital systems. In former years this was the main function of a department or a division of mental health. In different states these enjoyed varying degrees of local administrative autonomy. This concentration on hospital administration led to the criticism, in some instances, that the department did not represent mental health in its broadest implications and applications, but restricted itself to being a central hospital superintendency.

Scope of Functioning is Broadening

This attitude is rapidly changing because psychiatry itself in its application is undergoing marked alterations. The original basis of mental hospital administration was rather to give economical custodial care to a group of persons who were considered asocial to such an extent that they had to be confined to a mental hospital. In many places the state hospitals replaced local hospitals, asylums, poor houses, and similar local organizations taking care of the mentally sick. When Dorothea Lynde Dix and others highlighted the inadequacies of some of these local organizations, more and more state hospitals were introduced to care for this group of patients. From the point of view of the past, this was progress. As we look upon it today, however, it was not such a constructive move, because the patients became wards of the state and were often removed from their local community for treatment, thereby losing their personal community contacts.

In the past, no treatments or a very few ineffective treatments existed for the mentally ill. Many of our treatments today are still empirical because we lack knowledge about the causation of the most important mental disorders. Nevertheless, these various empirical treatments are achieving rather impressive therapeutic results. Since more patients improve or even recover under them, the community attitude towards psychiatry is changing, and the attitudes of the psychiatrist toward

patients and the community are also undergoing profound changes. Formerly the aim of the state mental hospital and that of the state department of mental health was to find the best and most economical method of custodial care for the mentally sick. Today the emphasis is more and more on treatment and research, and on training all personnel to be able to perform a therapeutic task. The department of mental health perceives more and more that its function is not alone in the hospitals, but that it has to concern itself increasingly with the emotionally disturbed in the community. It has to provide or stimulate the organization of facilities on the local level and to emphasize aspects of psychiatry which deal with treatment and not with custodial care. It is recognized that at least in some psychiatric illness categories we have over-hospitalized patients in the past and that many of these patients could be cared for in facilities other than state hospitals. The departments of mental health are also more and more preoccupied with the patients being discharged from the hospitals, how they should be supported in the community, how much psychiatric help can be given them, and especially how to cut the very large relapse rate among the psychiatric patients discharged from the state institutions.

Whereas in the past, psychotic patients were the main concern of the department of mental health, today it has to take care of many other psychiatric problems as well. It has to grapple with the problem of providing facilities for neurotic patients. It has to support programs on alcoholism, narcotic addiction, and psychiatric services in prisons and courts. It has to pay more and more attention to psychiatric services in schools and to many other aspects of psychiatry which formerly touched upon it only incidentally, because its main preoccupations were hospital organization and administration. The most important function of these departments still remains that of the administration of hospitals and schools, but in the future this will have to be integrated with the other psychiatric functions which I have mentioned. The departments of mental health and their commissioners are no longer engaged solely in the duties of a central hospitalization administration, but have to formulate psychiatric policies which touch upon the community as much as the hospitals and have to integrate administration, research, and training into a comprehensive whole.

Just as the organization of the mental health department varies according to local conditions and needs, and is changing with the changing needs, so individuals with different personality organizations and qualifications make good commissioners. While there is no simple formula for selection, a commissioner must have certain minimum qualifications: he should be well acquainted with the clinical aspects of psychiatry, with treatment procedures and with research goals.

Psychiatry in the past has been overloaded with administration because it could accomplish little therapeutically. The more we improve in our therapeutic endeavors the more we have to concentrate on this therapeutic aspect of psychiatry. This does not mean that administration and administrators are not of great importance; but it does mean that occasionally representatives of other branches of psychiatry should be invited into such administrative jobs as commissioner. In this way the job of administration can be blended more closely with clinical and research work, because these two aspects will increasingly dominate psychiatry now that it is becoming more and more of a therapeutic discipline rather than a custodial one.

One of the Commissioner's main tasks is to size up the environment in which he finds himself and relate the aims of this department program to the reality situation. This means patience in developing a program, because crash programs very rarely work; frontal attacks on long-entrenched traditional state budgetary practices, for instance, will not succeed. In most states changes can be accomplished only by evolution and not by revolution.

But an aim and a program are fundamental. Many difficulties arise, and progress does not take place if no program exists and the state office administration confines itself to the supervision of the existing routine machinery. This lack of program has become less and less noticeable during the past few years. In many places well thought out and organized programs are being introduced with beneficial results.

Role Should Be Professional, Not Political

The Commissioner's relationship to the Governor and to the political leaders in the legislature, to other administrative agencies in the state and to the profession cannot be expressed in a ready-made formula. My personal conviction is that in the field of health and mental health the Commissioner should be an expert in his specialty—not a politician. The departments of mental hygiene should not be political undertakings. The function of the Commissioner is to be a technical expert who can advise the Governor and legislature on this very important phase of health administration. He himself must be without political ambitions.

It is essential to the effective functioning of the Commissioner that he be in harmony with the administration which appoints him, and that they accept his program in principle. Yet his decisions and his actions must be based essentially on his professional knowledge and experience, and not upon considerations of expediency. Commissioners of health and mental health best serve the citizens of their state if they put at the disposal of the state their best knowledge of the medical discipline which they represent in the cabinet.

The Department of Mental Hygiene of the State of New York has many activities best described by giving the organizational scheme of the department. This will convey the manifold activities of a department which is the central policy-making and administrative agency of the state in dealing with mental health. In addition to the Commissioner, the department has a Deputy Commissioner, and five Assistant Commissioners. Each of the Assistant Commissioners is in charge of a division of the department. Under the divisions the different bureaus are grouped.

The first division of the department is that of the research and medical services. This division is in touch with psychiatric research in the different installations throughout the state. The largest research unit is the New York State Psychiatric Institute. In addition, six

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full-time research units operate in various institutions, carrying out the most extensive projects. In addition to the research in the institutions, two research units work in the field but are directly attached to the department. One is the biometrics research group in New York City and the other is the epidemiological research group in Syracuse. The statistical services of the department are under this division. The statistical office devotes its time to collecting routine data and information regarding the operations of the department and its institutions. This office is responsible for the preparation of the annual statistical reviews with respect to patients in the state hospitals, state schools, and the colony for epileptics. The statistical services are of invaluable aid in properly carrying out the planning functions of the department. In this division there are also the offices of the tubercular control services which correlate the function of the tubercular units in the state hospital system.

Professional Standards Coordinated

The second division in the department, also headed by an Assistant Commissioner, is the division of inpatient services. In this division are grouped the offices of medical inspection, nursing services, occupational therapy services, recreational therapy services and safety services. The titles of these services clearly indicate their functions even though the extent of such functions is not conveyed in the title. Essentially all these bureaus give leadership to the services they head and help to maintain a high standard of performance in formulating uniform professional procedures and in evolving programs for the employees in the different professional groups. The medical inspection is an especially important part of the department's operations. Through this service it is able to observe the operations of the hospitals and schools. It also gives opportunity to prospective directors of institutions to observe the operations of the different institutions from within the department before they are appointed directors.

The third division of the department is that of special services, which is comprised of two bureaus. The first is the educational bureau which has a supervisory and advisory relationship to the department's institutions in respect to their educational programs. The educational programs involve curriculum development and inservice training, as well as establishment of educational committees representing various local institutions to study educational problems. The second bureau in this division is that of the psychological services. This service conducts an interdepartmental intern training program which offers supervised clinical experience to graduate psychologists and also maintains inservice training programs. This bureau is also responsible for seeing that the psychological services are kept abreast of developments and for encouraging psychological research and new training techniques. In addition to activities within the department, it is also responsible for the psychological services in the state's correctional institutions.

The fourth division is that of the Community Mental Health Service. This division coordinates the community mental health activities of the Department of Mental Hygiene with the state-aided community mental health services. The program provides for the creation of local mental health boards and the establishment of local mental health services with state aid. Such services may include psychiatric clinics, psychiatric inpatient services in general hospitals, rehabilitation of persons handicapped by mental disorders, consultant and educational services to schools, courts, health and welfare agencies, parents and other appropriate groups. Another bureau in this division is concerned with the child guidance clinics. Child guidance and mental hygiene clinics are conducted in one hundred and two cities and towns throughout the state. These clinics make available expert advice in regard to treatment of children and adults who present various psychiatric problems. The bureau of social service, which is also in the division, advises the institutions of the department in the organizaton and development of social services and arranges training for social service staffs. The bureau evolves methods and developments for family care of mental patients. In this division there is also the very important bureau of aftercare clinics which take care of the patients on convalescent care. These clinics try to maintain patients discharged from the hospitals in the community and as far as possible try to reduce the relapse rate in these patients.

The fifth division in the department is the division of New York City services which coordinates the many departmental services in New York City. This division inspects public and private institutions and clinics, investigates the status of alien and non-resident patients in state institutions and arranges for the deportation or removal of such patients. The Assistant Commissioner in charge of these services is also designated to administer the Interstate Mental Health Compact now in force with several states. This compact provides for the removal of non-resident patients to their states of residence based not on purely administrative considerations as was formerly the practice, but on the mental and physical state of the patients as well.

The office of business management has a finance section which supervises the financial operations of the department and institutions, prepares the budget, and does a periodical inspection of the merchandise records of the institutions. The office of business administration also is in charge of the nutrition services, the reimbursement, equipment, farming, and laundry services. This section is in charge of the Business Assistant to the commissioner, who has the rank of Assistant Commissioner.

Institutional Personnel Plans Organized

The Department of Mental Hygiene also has an office of personnel administration. This office formulates, directs, and supervises a comprehensive personnel program for the institutions of the department and develops a central personnel unit in relation to institution requirements. It serves as a liaison between the institutions and the Department of Civil Service. This office also collaborates with institution directors in establishing organized personnel policies and assists the directors in developing training programs, service rating procedures, and methods of orientation and guidance of personnel.

The office of engineering services devotes its work to

the manifold construction and engineering problems of the department and plans, from the departmental point of view, the new installations. It works in close cooperation with the State Architect and the Department of Public Works.

The office of the counsel supervises and correlates the legal matters of the department and its institutions. This includes a continuous legal information service, advice, legal drafting, dissemination, and interpretation of legal opinions coming from the Attorney General and different courts. It reviews and refers matters to the Department of Law for court action. It also drafts legislation and follows and reports on all bills which affect the department during the legislative session.

The office of publications and public relations handles the matters concerning public information and education. It is responsible for the planning and editing of the monthly paper, *Mental Hygiene News;* the annual reports of the department and its institution directors; handbooks and technical guidance papers; and popular literature explaining the principles of mental hygiene. This office supervises press relations and information given to radio, television, and other public communication media. It coordinates the additional activities of the department with those of other state, national, or local agencies. It acts as a clearing house of information in the field of mental hygiene in relationship to local groups throughout the state.

The office of planning and procedures of the department advises on matters of program, policy procedures, and organization. It makes studies determining the work load, work methods, and standards and equipment needed. When requested, this office investigates administrative and operating problems and recommends the appropriate action to be taken.

Finally, the general administration of the department is in the office of administrative services. This office includes the management of the central office and its organization. It also handles the records of all patients in the state and privately-licensed institutions. It attends to correspondence relating to patients, contacts with the institutions and other departments on matters of departmental policies and regulations.

Freedom from Details Would be Ideal

This description of the operations of the Department of Mental Hygiene may give an inkling of the many responsibilities of the department. The commissioner is informed about the operation of the different offices and divisions by the persons in charge of them and keeps an overall interest in the operation of the different phases of the department. Ideally, the commissioner and the assistant commissioners should be mainly involved in the general supervision and in the planning. Unfortunately, the many administrative details and decisions which arise do not permit this ideal situation.

I sincerely believe that the commissioners of mental hygiene and their deputies and assistants can only do a forward-looking, effective job if they are supported by an organization which is able to relieve them from certain routine duties, thus permitting them to pay more attention to the broad planning and execution of administrative policies. To be effective these policies must be based on clinical knowledge, familiarity with research information and techniques and with administrative procedures.

SK&F FELLOWSHIP COMMITTEE AWARDS FOURTEEN GRANTS

Fourteen grants totaling $38,454 were made in March by the A.P.A. Committee administering the Smith, Kline and French Foundation Fellowships in Psychiatry. This is the largest amount awarded in one year under the Foundation's total grant of $90,000 for the years 1955 through 1957.

Five state hospitals were among the recipients: **Montana State Hospital,** Warm Springs, received a one-year grant to pay traveling expenses of a teaching team from the University of Utah. The team, which will consist of a psychiatrist, clinical psychologist, psychiatric nurse and psychiatric social worker, will conduct a training program at the hospital for the psychiatric staff. **Camarillo State Hospital,** California, has embarked on a training program of teaching seminars and conferences conducted by psychiatrists and neurologists from medical schools and hospitals in the Los Angeles area, for one year. Another grant, to **Langley Porter Clinic** in San Francisco, Calif., will permit an extension training program for 10 ward physicians in the seven northern California state hospitals. These men will receive four hours of training a week, for 16 weeks, in psychodynamics and psychotherapeutic skills. The grant to **Metropolitan State Hospital,** Waltham, Mass., will enable the hospital to employ a psychiatric social worker to supervise student-volunteers from Harvard College, Radcliffe College and Brandeis University. These students will assist in preparing patients for discharge, contacting the relatives, and in some instances help secure job placements for discharged patients. The grant to **Vermont State Hospital,** Waterbury, will permit two medical students from the Vermont College of Medicine to participate in clinical and research projects at the hospital in the summer of 1957.

Grants to other institutions included one to **Temple University Medical Center** in Philadelphia, to conduct a course in psychosomatic medicine for psychiatrists in public hospitals and selected general practitioners and internists. Five other medical schools—at **Tulane, North Carolina, Minnesota, Chicago,** and **Boston** universities—plus the **Mayo Clinic** each received grants to permit varying numbers of medical students to take part in psychiatric research and clinical activities.

The other two grants were awarded to individuals: **Dr. Bonifacio A. De-Leon, Jr.,** Assistant Professor of Medicine at the University of Santo Tomas, in Manila, the Philippines, has a one-year stipend to study psychiatry at Baylor University School of Medicine in Texas. **Dr. W. Gordon Lamberd,** of Winnipeg, Manitoba, Canada, has a 12-month Fellowship for training in psychotherapy and research methods at the Mayo Clinic.

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Professional literature available upon request.

1. Figurelli, F.A.: Indust. Med. & Surg. 25:376 (Aug.) 1956.

Wyeth

Philadelphia 1, Pa.

Experimental Management of a Chronic Ward

By ROBERT E. PACE, Asst. Chief Anthropology, Veterans Administration Hospital, Downey, Illinois

IN THIS DAY of highly specialized therapies and treatment formulas, chronically ill patients somehow get lost in the shuffle of progress. As residue of intensive treatment wards they are, in effect, shipped out of sight and mind to one of many back wards. One study found that the probability of a patient's being discharged during the first year of hospitalization increased twenty percent (42-62%) between 1916 and 1950, while the probability of release after two years actually decreased (11-10%) during the same years. In our hospital, patients with five or more years of hospitalization make up approximately two-thirds of the NP population. Other public mental hospitals show comparable figures.

Administrators are immediately concerned with the enormous chronic population. They have to deal with the demands for space, for trained personnel and custodial care, demands that take huge chunks from available hospital resources while contributing little to therapy goals. It was in consideration of the administrative problems rather than of another therapy formula that the experiment described here was undertaken.

Since the object of the experiment was not to search out either cause or cure of mental illness, a functional rather than an etiological investigation was made. It was based on the premise that a reciprocal relationship existed between the behavior of patients and the situation in which they found themselves. We wanted to find out if the behavior of long term chronic patients could be altered in a desirable direction by manipulating the hospital situation. The question encompassed several specific hypotheses, which may be stated as follows: if a change in the situation is experienced by the chronic patient, it will be accompanied by a change in his behavior.

Before introducing the experimental changes, the behavior of the patients and their environment were studied. These observations served as a base line for later comparisons. Then situational changes were introduced and finally patients' behavior was again studied. Comparative analysis of patient behavior before and after the change in the situation allowed the use of the same group of patients for experimental as well as control purposes.

Four basic techniques, each numerically symbolizing various aspects of verbal, motor, or gregarious behaviors, were selected or designed for the experiment. They were: (1) Mobility Index, which measured the movement of individuals vis-à-vis others and the physical facilities of the dayroom; (2) Kandler-Hyde Socialization Activity Index, which recorded inactive, active not socializing and socializing behavior; (3) Interaction Protocol which recorded direction, goal, emotional overtone, and outcome of verbal actions; and (4) Multidimensional Scale for Rating Psychiatric Patients (MSRPP), which translates 62 scaled items into categories of psychopathology. These techniques, along with others, sampled behaviors before and after the ward situation was changed.

Thirty-five World War II male patients assigned to one of the "most deteriorated and regressed wards" were chosen to serve as control and experimental subjects. They averaged 36 years of age, eight years of hospitalization (the last four years on the same locked ward), and had failed to respond to the available therapeutic measures. All had long histories of management and care problems, from soiling and tube feeding to combative behavior and elopement. Baseline measurements were taken between June and November, 1954. The experimental period lasted from November, 1954 through August 1955.

Pre-experiment Situation

The situation was described in terms of the physical milieu, ward routine, and social organization of patients and personnel. The social organization, i.e., the shared system of formal and informal rules, joined the physical milieu and the routine in a more-or-less meaningful and significant context for participants. One aspect was noted by a newly arrived observer who was struck "without warning" when he unwittingly occupied a chair that "belonged to" the offended patient. "For the next few days I changed chairs a number of times in response to very apparent cues, such as increased verbal hallucinations or ritualistic behaviors—apparent because my presence or absence brought immediate increases or decreases in their frequency," he observed. "Gradually my comfortable living space was confined to that of the aides although I had hoped to avoid identification with other personnel."

Dayroom space rules evidently applied to aides as well as patients. They were observed three times as often in the forward part of the dayroom as in the middle or rear dayroom. One aide reasoned, "Those boys back there (rear) do better if we just stay clear of them. It just keeps them upset if we hang around back there. Now these boys that hang around here (forward), you can talk to them." And indeed he was right. Analyses of thousands of observations proved that "good contact" patients clustered around the aides while "hostile" and "poor contact" patients were consistently found in the rear of the dayroom. This spatial pattern varied with the routine, but documentation left no doubt that it was understood—and enforced—by both aides and patients.

In addition to "good contact" and "hostile", some sixty other patterns of behavior commonly recognized by pa-

Author's note: *It was the sincere interest in improving the lot of the chronic patient on the part of Dr. Lee G. Sewall, former Manager, and others of Downey VA Hospital, that made this study possible. Credit for what was learned goes to Dr. Robert I. Cutts, ward psychiatrist, Mrs. Lois Perrewe, psychiatric nurse, the eight research aides, and to Dr. E. A. Kennard, senior anthropologist.*

tients and personnel were found clustered in certain areas and identified with certain patients. For example, patients described as good contact, neat, ward boss, pest, teaser, patient aide, worker and griper clustered about the aides and fore part of the dayroom. Timid, giggler, assaultee, fair contact and quiet patients were found along one wall while along the opposite wall and the rear, the poor contact, hostile, untidy, hallucinator, ritualistic and sleeper patients prevailed. One could with considerable accuracy predict where a patient known by certain behaviors would be found in the dayroom, or what behaviors to expect in any given area.

Patterns of preference-deference correlated closely with the above spatial patterns. The patients clustering around the aides ranked high in preference-deference relations with aides and the remainder of the patients. The rear of the dayroom patients ranked lowest. From weighting behavior patterns of the five highest and the five lowest patients (rated by ward personnel) every patient was ranked in relation to others. The significance of ranking among the patients was expressed in verbal interaction as well as sociometric patterning. With whom a given patient would interact, the obvious goals of the interactor, and consequence of the interaction were closely related to the relative rank of the interacting patients.

The following incident reveals how closely the physical milieu, the ward routine, and social organization were integrated.

P-1, a high ranked patient, was informally delegated responsibility for maintaining the clothing room and distributing clothing to patients. A-1, a night aide, routinely brought the "Sunday clothes" from a central clothing room each Sunday before the patients got up. One Sunday, while looking for a missing suit, he allowed the patients to oversleep. When P-1 arose, he verbally rebuked A-1 for allowing the patients to oversleep, for messing the clothing room and failing to have all clothing on hand. A-1 finally lost his patience and threatened to have P-1 transferred to a discipline ward unless he shut up and helped with the dressing of the patients. At this point, three other high ranked patients joined P-1 in deriding A-1. The dayroom was in an uproar. Several patients were hallucinating loudly, many were wandering about half-naked, and four had gone back to bed. The time when this group of patients was to join others of the building to go to the central dining hall was approaching. Being late would not only disrupt the routine for the one building but for patients in other buildings who used the dining hall. When order was finally restored, the relief aide complained that A-1 did not "know" the ward well enough to run it. In effect, the routine, and thus the social organization, had momentarily collapsed, making the situation as dangerous as it was unpredictable.

With some understanding of the type of situation in which behaviors occurred, the inquiry tackled the two questions: (1) Could some change in the situation alter patient behavior in a desirable direction? (2) If so, could it be done without placing added pressures on the already overworked hospital economy?

Experimental Changes

In addition to the missing suit incident, many instances were recorded demonstrating an almost total dependence of the social organization upon a rigid locked-ward routine. Further evidence occurred when it became known that the group of patients was to be moved to an open ward. There were widespread predictions of wholesale elopements, mass injuries and general chaos. Without a locked-ward routine it was believed all order, and thus control of the patients, would be lost. These predictions failed to materialize, mainly because the social organization was extended and strengthened to the point where it withstood changes in routine. Reinforcement and support of the social organization was the key to the experiment. Briefly it involved the following steps:

1. Localizing, and focusing the attention of the patients upon themselves as a group. The specific changes included moving the 35 patients to a relatively isolated open ward, permitting them to select distinctive clothing, giving the group a name (RG—Rehabilitation Group), encouraging them to arrive at alternative scheduling of activities, etc. These changes encouraged the patients to develop a group identity over and above that of "patient".
2. Formalizing and supporting the already existing system of rank among patients, specific changes included delegation of granted responsibilities and common means of symbolizing these. Thus the ward boss was given the task of supervising various aspects of the routine. His now formally recognized position was made "real" by making office space available to him, asking him to participate in management conferences, etc. He in turn delegated responsibilities to several assistants who were provided with somewhat less valued symbols of rank.
3. Increasing group solidarity by creating a climate wherein the opinions and values of all members (realistic or not) were frequently aired before the entire group. This stimulated acceptance of consensual standards of conduct which were enforced by group pressures of support and censure.
4. Redefinition of the traditional roles of the nurse and aides. From an administrative office job the nurse moved to an active participant role with patients in the dayroom. Besides supervising the aides, the nurse stimulated interaction among patients during impromptu group gatherings as well as during formal daily meetings. Eight new aides were assigned to the patients (the same number as before the experiment began). In addition to traditional training they received instruction in basic occupational therapy and recreation without extending the length of their classroom training. In consultation with several ancillary services, the aides carried out activities normally conducted by a limited number of technicians. Consequently, the activity program became more flexible and had greater continuity. At the same time a number of skilled personnel and specialized facilities were released for more intense efforts elsewhere in the hospital.

Changes in Behavior

By providing for a flexible and continuous routine, making explicit the relationships between patients, arranging formal and informal group discussions, and giving high rank patients formal responsibilities, a climate more conducive to responsible

social behaviors was created. The rate of informal activity among patients increased by 61%, and the number of those active who were, at the same time socializing, more than doubled. The average number of verbal interactions per observation unit rose from 42 to 90. Significantly, the patients now sought out personnel more frequently, and asked for general information more often than for cigarettes and other personal services. Similarly, personnel engaged patients in informal conversations more than twice as often. Seventy-three percent of personnel interactions with patients before the experiment involved instructions of personal hygiene, ward cleaning chores and the like. During the experiment such routine instructions decreased to 35%.

For both patients and personnel the frequency of friendly and satisfying verbal actions increased significantly. The percent of verbal rejections decreased. However, the percent of patient interactions wholly or partly unrealistic in content rose from 15% to 34% during the experiment. It has been suggested that this increase reflected a freer milieu for reality testing.

An analysis of psychopathological behaviors (MSRPP) showed that these decreased as follows: Paranoid projection 60%, activity level 48%, perceptual distortion 14%, motor disturbances 13%, withdrawal 11%, conceptual disorganization 10%, compliance 2%. On the other hand, melancholy agitation increased by 6%, retarded depression by 8% and belligerence by 131%. It was the consensus of the researchers that the increase in belligerence over submissiveness reflected a trend toward independence.

The structure of the patient group underwent an accordion-like change. Extreme high and low ranked behavior patterns tended to disappear. As a group, the tendency was for an upward movement with much greater clustering of patients in what had been sparsely occupied middle positions of a hierarchy. Initially, 13 of the 35 patients were known as elopers. Three of those elopers left the hospital grounds during the 10 month experiment and two of these during the first weeks. Two other patients eloped, but all were shortly returned. Feeding problems disappeared, as did soiling (four patients were initially soilers.) Physical altercations were no longer a concern, all patients could shave and bath themselves with little or no supervision, straggling to meals and off-the-ward activities was no longer a problem, and the one withdrawn catatonic patient had full ground privileges. Except for periodic observation duties, there was little need for more than one aide at any time. Still these patients required more supervision than other ground-privileged patients. Most were not capable of assuming off-the-ward work responsibilities required of privileged patients, and prognoses were still far from good. Nevertheless, with support of other group members and the experienced aides, 79% of these patients were judged improved enough by the ward psychiatrist to be continued as privileged patients on an open ward at the end of the experiment.

Effects of Experiment

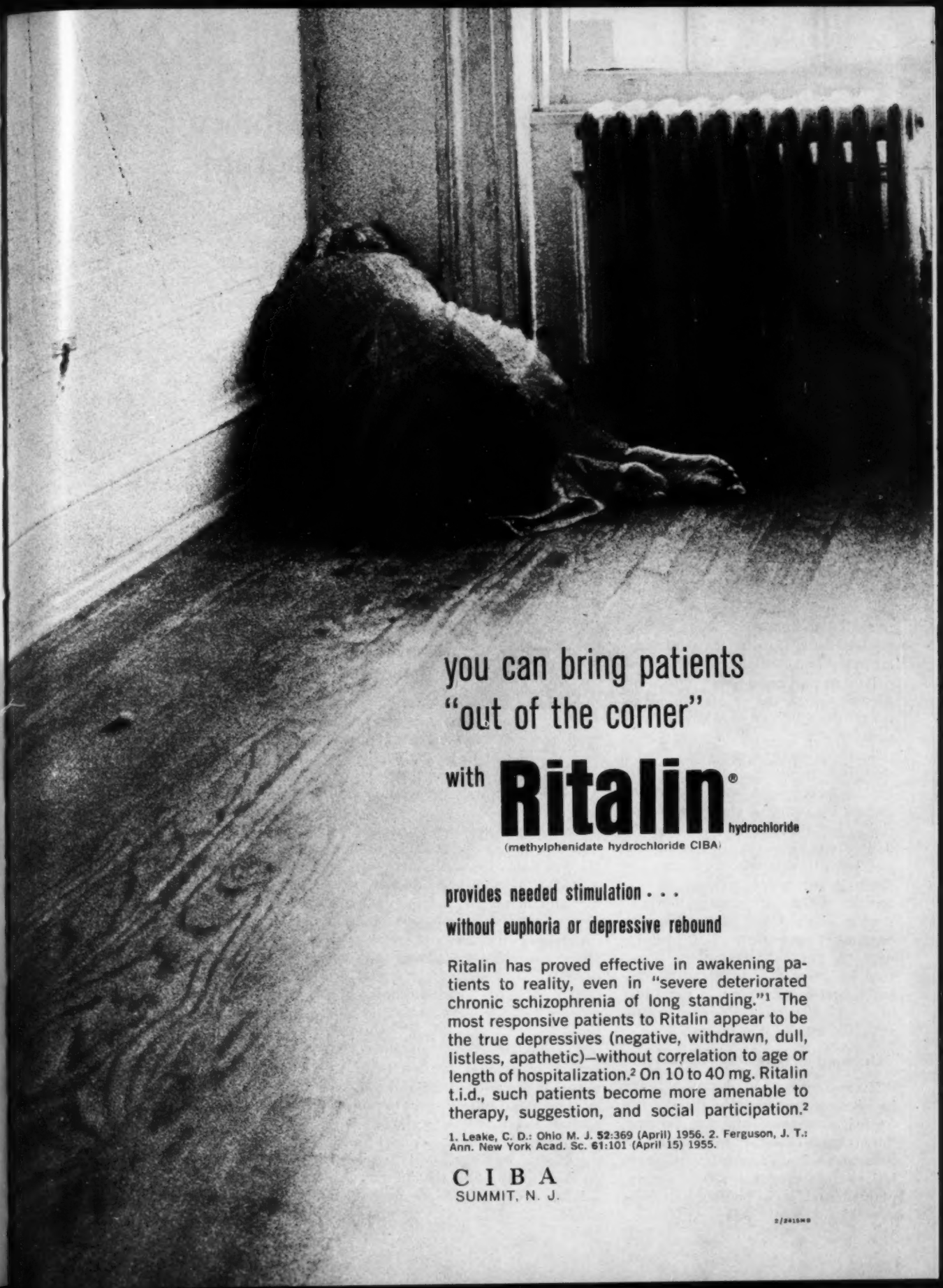
During the year following the experiment, most of the experimental patients became dispersed throughout the hospital and consequently removed from the situational context of the experiment. A year later, one patient had become a member-employee of the hospital, one was home on trial visit, 16 others had at least maintained their prior improvement. The remaining 17 had been reassigned to their original building, or were little or no better off than before the experiment.

The experiment involved only one of the four wards of patients assigned to the original building. What happened to the patients of the other three wards who received the traditional treatment and care? Systematic records of behavior were not made on these wards, but a comparison of number of trial visits, ground privileges granted and similar movement from these locked wards provides another rough measure of what happened to the experimental group. Thirty-seven percent of the patients who did not participate in the experiment, and who remained on the original locked building, improved enough to be moved from the locked building. Seventy-nine percent of the experimental patients showed similar improvement. It should be noted that the experimental group was considered the most "deteriorated and regressed" by the building personnel prior to the experiment.

The experiment demonstrated how much can be done to reverse the tendency of chronic patients to withdraw and vegetate. The essential changes in the situational context depended neither upon special facilities nor larger numbers of personnel. Specific means of cultivating group awareness among patients do, however, depend upon ingenuity in the use of what resources are available, including that of the existing organization among the patients. Plans are presently under way to apply many of the experimental findings to larger units of chronic patients in this hospital.

People & Places

Dr. William M. O'Brien, formerly Assistant Superintendent of Mendocino (Calif.) State Hospital, is the new Superintendent and Medical Director of Modesto State Hospital. He relieves **Dr. Freeman H. Adams,** Superintendent and Medical Director of Stockton State Hospital, who for several months combined the duty at both institutions. . . . **Mr. Harold J. Pilon** has been appointed director of hospital administration for the Kentucky Department of Mental Health. . . . **Dr. Robert C. Hunt** has resigned as assistant commissioner of the New York Department of Mental Hygiene to become director of Erie County (N.Y.) community mental health services, as of April 1. . . . **Dr. Ernest S. Klein,** until recently medical assistant superintendent of Elgin State Hospital, Illinois, has become superintendent of the Peoria State Hospital. He was replaced at Elgin by **Dr. Daniel A. Manelli.** . . . A bill passed in Maine approved the change of name of the Pownal State School to **Pineland Hospital and Training Center.** . . . In Ontario, **Dr. B. H. McNeel** has been named chief of the Division of Mental Health, replacing Dr. R. C. Montgomery, who has retired, and **Dr. C. A. Buck** has been named Director of Ontario Hospitals.


you can bring patients
"out of the corner"
with Ritalin®
hydrochloride
(methylphenidate hydrochloride CIBA)
provides needed stimulation . . .
without euphoria or depressive rebound
Ritalin has proved effective in awakening patients to reality, even in "severe deteriorated chronic schizophrenia of long standing."[1] The most responsive patients to Ritalin appear to be the true depressives (negative, withdrawn, dull, listless, apathetic)—without correlation to age or length of hospitalization.[2] On 10 to 40 mg. Ritalin t.i.d., such patients become more amenable to therapy, suggestion, and social participation.[2]
1. Leake, C. D.: Ohio M. J. 52:369 (April) 1956. 2. Ferguson, J. T.: Ann. New York Acad. Sc. 61:101 (April 15) 1955.
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The Employees' Responsibility in a Fire Protection Program

By THOMAS J. DOVGALA, JR., Chief of Fire Department

New Jersey State Hospital, Trenton

THE FIRE PROBLEMS at our hospital are like those of any city. There are buildings housing patients, homes and dormitories for employees, a laundry, a paint shop, a bakery, sewing shops, a machine shop, a mason shop, a carpenter shop, a lumber shed, a drug room, a storage building, a laboratory, farms and other establishments. In order to protect these buildings and, more important, their occupants, against the hazards of fire we have evolved a program of prevention and protection which stresses vigilance on the part of all hospital employees. This program, it should be mentioned, is made possible only by the vital interest of the hospital administration.

Policies and regulations concerning fire prevention and protection are set up by the Chief of the Fire Department. He and three Assistant Chiefs (all professional firemen) carry out a thorough inspection program. Each building receives a complete inspection at least once a month and especially hazardous areas are checked daily. Conditions that can be cleared up immediately are taken care of through the chief making the inspection. Others are brought to the attention of the Chief of the Fire Department, who turns the problem over to the administration. Upon completion of an inspection, a written report is submitted to the Chief of the Fire Department by the assistant chief making the inspection.

Orientation Given All Employees

Every person employed by the hospital receives an orientation course on fire prevention and fire fighting. The classes last approximately an hour and a half. The rules and regulations regarding fire safety are explained and it is pointed out why these rules are necessary. Each employee receives two copies of the rules and regulations regarding fire, one of which is to be signed by him and placed in his personnel folder. The other is kept by the employee for reference.

The employees are instructed on how to transmit the alarm of fire and also on how to evacuate the patients should a fire occur. In addition, they are instructed in the use of first aid firefighting appliances located throughout the hospital. These include: cartridge-operated water extinguishers, Foamite extinguishers, carbon dioxide extinguishers, dry powder extinguishers and stand-pipe hose.

A check of these appliances, as well as of general fire safety on all wards, is provided three times a day by the charge nurses and attendants. Each is instructed to begin his tour of duty by checking the crucial points listed on a small yellow card posted on each ward. (See above.)

When these instructions are carried out we are assured that the personnel on duty know where the nearest alarm box and fire extinguisher are located. The responsibility for fire safety is placed on the people who are closest to the places where fire can do the most damage. In the event that the fire chiefs on their inspections find that any of the above items are not functioning properly, disciplinary action is taken against the employee responsible. It takes only a few minutes for the employee to carry out the ward inspection plan. Out of an eight hour tour of duty, this is not too much to ask for the results obtained.

The Volunteer Fire Department

All employees are instructed to transmit an alarm immediately upon discovering a fire and then to try to extinguish the blaze with the first-aid firefighting equipment. The alarm summons our Volunteer Fire Department, which is made up of the 65 members of the maintenance department.

Ward Fire Inspection Rules

IN THE EVENT OF FIRE—Keep CALM—Don't RUN

REMEMBER Fear and Panic can do as much DAMAGE as FIRE

1. Tested and checked Key in FIRE ALARM BOX
2. Checked Fire Extinguishers—that nozzle opening is clear—EXTINGUISHERS ARE IN PROPER POSITION AND READY FOR USE.
3. Tested and checked Key in hose CABINETS
4. Checked Standpipe hose and connections—Hose connected and properly racked—Report Leaks
5. Checked clothes ROOMS FOR FIRE HAZARDS.
6. Checked Mop Closets—NEAT AND ORDERLY
7. Checked FIRE STAIRWAY AND FIRE DOORS—Stairways and Doors are unobstructed.
8. In the event any of the items listed above or any other hazardous condition is discovered —NOTIFY YOUR SUPERVISOR AT ONCE.

NOTE

All Charge Nurses and Charge Attendants shall upon the beginning of their tour of duty inspect Wards for the eight fire preventive items listed above.
When inspection is completed it shall be noted in the Day Book as follows: "Ward inspected for fire safety."

The Department's activities are centered in our fire house. Here is kept the major firefighting equipment: a 750 gallon per minute Ward LaFrance pumper; one Chevrolet truck with front end pump, converted into a utility truck carrying much of the needed fire equipment; one 1000 g.p.m. American LaFrance pumper, and one White service truck equipped with various size ladders, ranging from a 65-foot extension down to 12-foot roof ladders. Other equipment includes a portable generator and light unit, smoke ejector, resuscitator, hose, wet water, foam generator, deluge set, and combination fog and solid nozzles.

The members of the Volunteer Fire Department have a training class on the last Friday of each month, in addition to the training received during the monthly fire drills. The chief officers of the Fire Department instruct these men in the proper methods of fire fighting, how to use the equipment which is carried on the apparatus, how to operate the pumps on the various engines properly, and how to protect themselves from injury during fire operations. A chief or assistant is on duty 24 hours a day to supervise fire fighting.

If outside help is needed to control a fire, we have three alarm boxes, located in the Boiler House, to summon the City of Trenton Fire Department. When any one of these boxes is pulled (according to the location of the fire) we receive three engines, two trucks and a Deputy Chief from the city department.

Surprise Drills Held

Monthly evacuation drills are conducted with patients, ward personnel and the Fire Department taking part. Without advance warning, the chief notifies one of the ward personnel that there is a fire on the ward or in the building. The person so advised acts exactly as if he had discovered a fire, transmitting the alarm, evacuating the patients, and preparing to extinguish the fire. A plan has been set up so that other personnel come to the aid of the ward in trouble and assist in evacuating patients and extinguishing the fire. In the meantime, the Fire Department is on the way to the scene, where they are given various fire fighting maneuvers to perform.

There has been much controversy about whether regular fire drills with bells ringing and sirens sounding has an adverse effect on mental patients. Our experience has been that it does not. In fact, when an actual fire does occur, the patients go calmly through the procedures and those elsewhere in the hospital are not alarmed. It has become a matter of routine to them and to the hospital as a whole.

There are, of course, many other precautions which must be taken to prevent fire. What this article has attempted, however, is to show how the hospital employees can play an important part in the constant vigilance against fire. In doing so they are helping fulfill their responsibility towards the mentally ill individuals entrusted to their care.

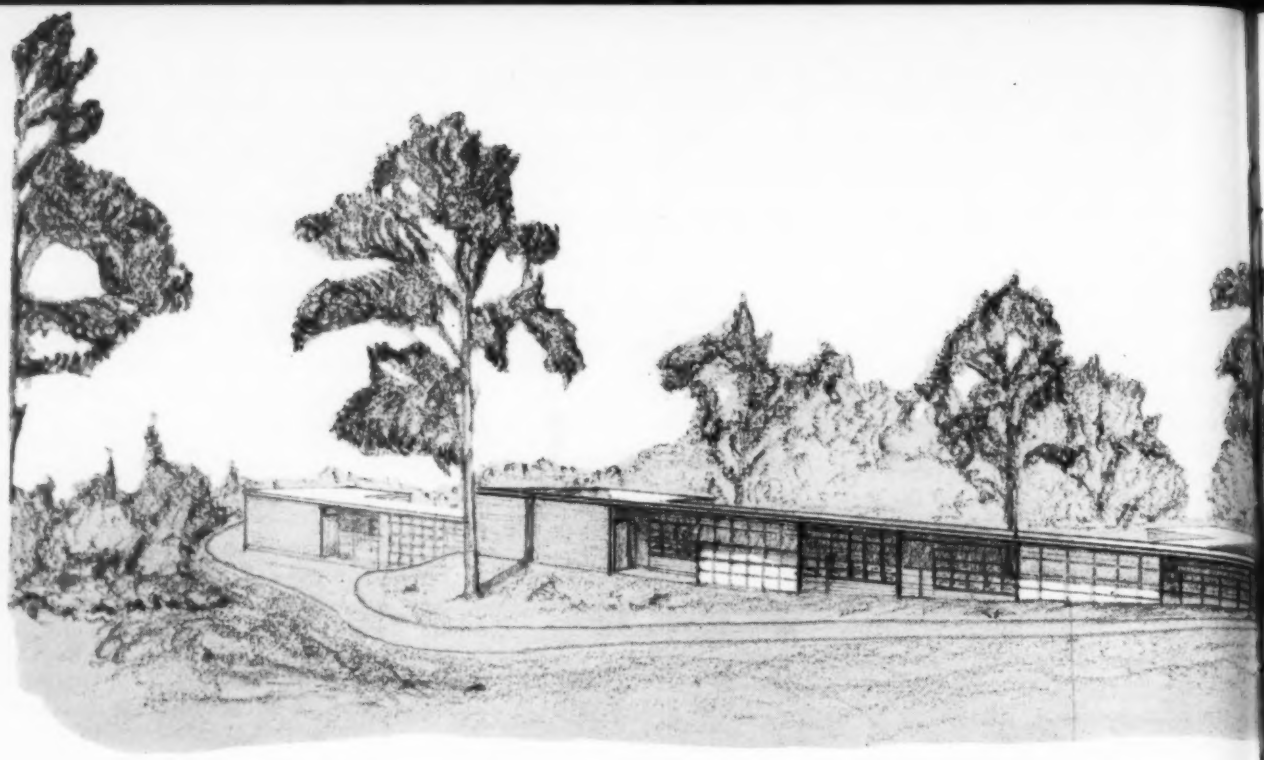
PRIVATE LIVES

By Dr. Whatsisname

"THE TROUBLE with Army life" a recruit once said," is that you can't take out your girl's picture and look at it fondly without a bunch of guys laughing at you." This complete destruction of privacy is one feature of military life which shocks more recruits than the possibility of physical danger. The cramming together of people, so characteristic of urban and suburban life, has made more necessary than ever before the construction of walls between them. You can afford to tell intimate secrets to the man you sit with in the smoking compartment of the Pullman car. You will never see him again. But you cannot divulge such intimacies to your neighbor.

The modern mental hospital is ingeniously contrived to destroy privacy. Not only must patients sleep together and eat together, but they cannot even enjoy solitude in what must surely be the last bastion of privacy—the toilet. Many mental hospitals cannot give floor space to nighttables or dressers, so that it is hard for the patient to conserve his own books, toilet articles, family pictures, personal papers or clothing accessories.

A domestic animal has no privacy, and the stripping away of a human being's privacy tends to put him in the category of a pet animal—to be taken care of, even to be loved in a way, but to be degraded by being denied the right of privacy. And, make no mistake about it, a degradation is what it is. You cannot give privacy to a determined suicidal patient, and there are destructive ones who cannot be trusted alone in a bathroom. But such difficult patients constitute only a small proportion of the hospital census. It is a job for architects, administrators and nurses to design the hospital and shape its climate so that the patient's privacy will be respected. Whatever contributes to human dignity is good mental medicine. The mind of man is surely cunning enough to solve somehow this not-too-difficult problem: privacy in a hospital ward. And the first step toward solution is to recognize the challenge of the problem.



Housing as a Problem of Personnel Management

By PETER W. BOWMAN, M.D., Superintendent
Pownal State School, Pownal, Maine
and ROBERT E. WRIGHT, Architect, Lewiston, Maine

DURING A PERIOD of forty-five months, 613 employees have left our institution. Valuable time and funds have been invested in recruiting new personnel, both at the professional and sub-professional level, but our attempts have not met with much success. Vacancies have caused temporary discontinuation of programs, and have to some extent even prevented consistent, adequate everyday care of our patients.

An analysis of factors influencing the high turn-over demonstrated that the location of an institution may be of considerable importance to people considering employment. The availability of community resources is also important.

In our case, the institution is located in a rural area, with no immediate access to community housing. Housing available for employees at present consists of sparsely furnished single rooms with few conveniences. Some are located in patient dormitory buildings, and do not provide real privacy. Others are in two brick structures reserved for employees. Soundproofing, bathroom, kitchen and storage facilities leave much to be desired. Garages are not available at all, yet they are of considerable importance in our northern New England climate.

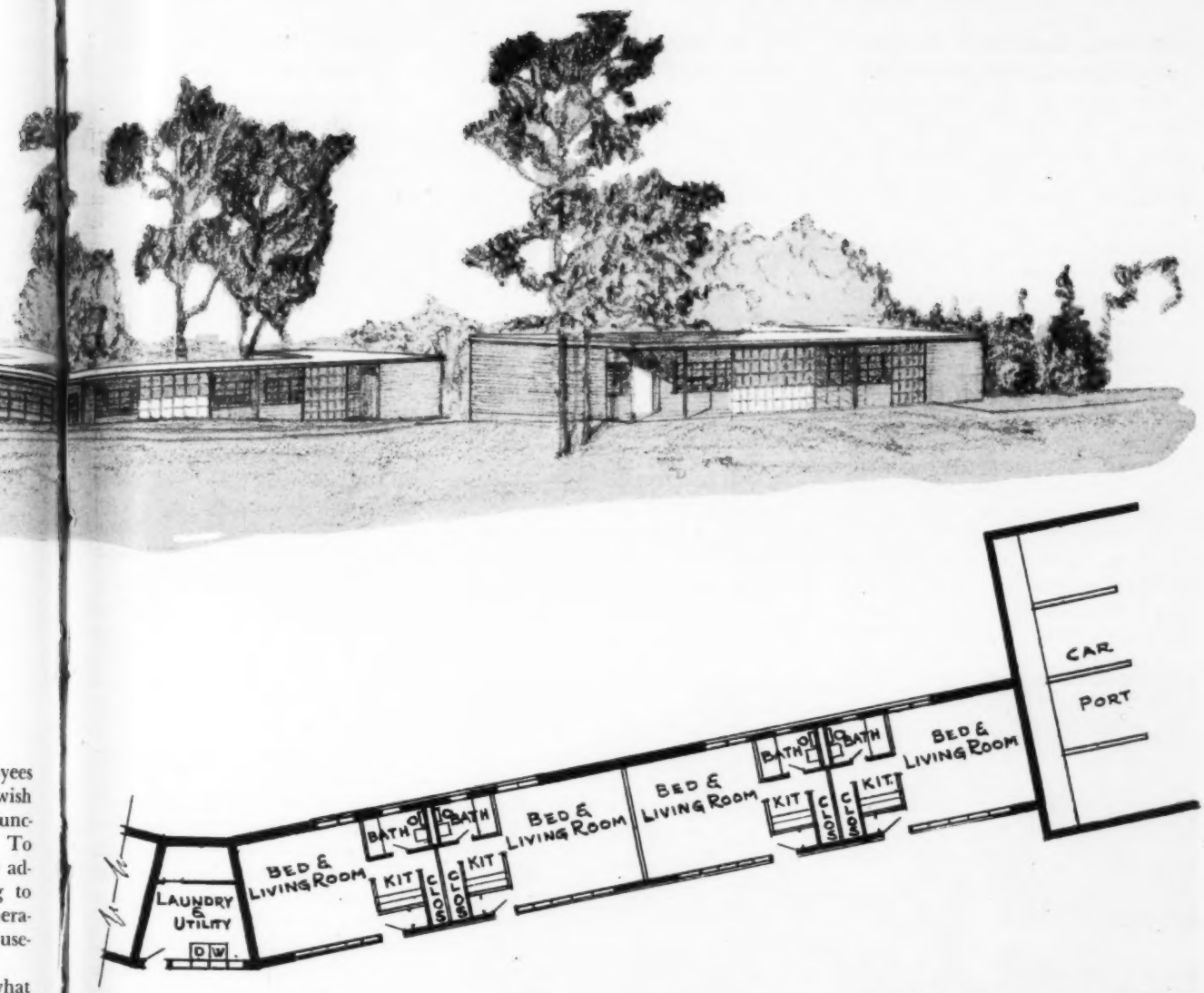
During the past three years, three new houses have been built for institutional officers; another was rebuilt and an apartment has been added by alteration of unused space. Yet completion of these limited projects brought very little relief, especially because additional appropriations make possible a considerable increase in personnel.

Employees' Needs Polled

Accordingly, $271,720.00 has been made available to construct new housing facilities for our staff. If these limited funds are to give the maximum result, the housing must be designed according to the needs and wishes of those who will call it their home. We have therefore spared no efforts to meet such requirements. A representative sample of employees was interviewed. In each case the wish for privacy, convenience and functional design was emphasized. To these requirements, we added our administrative concern for keeping to a minimum expenditures for operation of utilities, year-round housekeeping and maintenance.

The architect met our somewhat complex needs with a plan for motel-type units, providing a total of 19 apartments. Two buildings each contain eight "efficiency apartments" consisting of a combined living and bedroom, a kitchenette, bathroom and closet, with a laundry and utility room in the center of the building, serving all eight apartments. At either end of the buildings are carports with space for four cars each, so that each apartment has easy access, via a covered walk extending along the front of the building, to its own parking space.

The other three apartments are in a single building with a carport at one end and a laundry-utility room at the



other. These are larger, having a separate living room, a bedroom, kitchenette, bathroom and closet. Three more apartments can be added to this unit as required.

The units, particularly the three larger ones, are intended primarly for professional staff; however, subprofessional workers will be given consideration if vacancies occur.

The hospital supplies all furnishings, linen, kitchen utensils and other basic needs. The housekeeping department cleans the apartments daily without charge. However, housing is not included in salaries or wages, and the employees will pay rent.

Construction Details

The exterior walls are of concrete block faced with brick and the interior partitions are also of concrete block, thus providing a nearly fireproof structure. To relieve the monotony of so much masonry, the front wall of each unit is of typical residential wood stud construction. The roof is of precast cored concrete plank, forming the ceiling of all rooms. The floor is a cork patterned asphalt tile, on concrete placed on grade. Bathrooms have ceramic tile floors and walls.

Kitchenettes are of the apartment type, with combined range, refrigerator, sink base and upper storage cabinets, all of metal with individual mechanical exhaust systems. Heating is by steam from the central plant of the institution, using convector radiation.

To soften the hardness of so much masonry in living quarters, a multicolored flat finish flecked paint was chosen for interior walls, since the budget precluded plastering. With care in the selection of drapes, we believe that we can create a cheerful, homelike atmosphere in a structure which is not only fireproof, but also is soundproof between dwellings.

The contract has been awarded at $222,520.00.

DEPARTMENTS Including THE PATIENT DAY BY DAY

Hospital Speakers' Bureau Arranges Community Talks

The Galesburg (Ill.) State Research Hospital encourages community interest in the hospital through its "speakers' bureau" operated by Robert Mackie, Public Relations Officer.

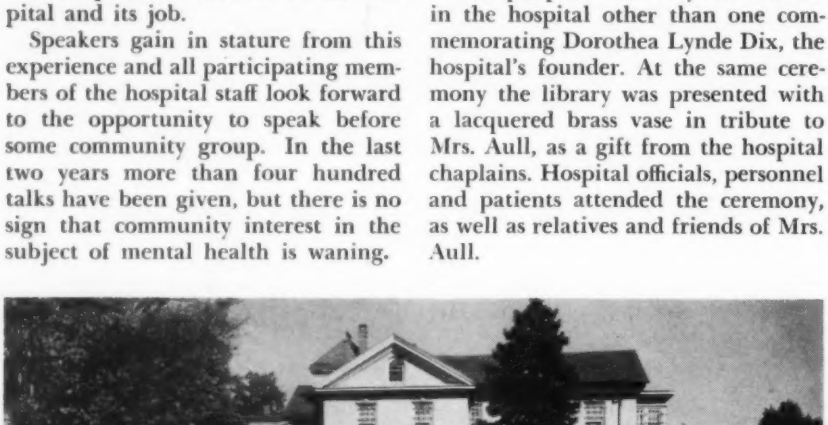
Several talks are given weekly throughout the year to community groups, some more than fifty miles away. There is no question in the minds of those who participate in the program that this policy has paid dividends through an increasing favorable public awareness of the hospital and its job.

Speakers gain in stature from this experience and all participating members of the hospital staff look forward to the opportunity to speak before some community group. In the last two years more than four hundred talks have been given, but there is no sign that community interest in the subject of mental health is waning.

Hospital Librarian Honored Posthumously

An impressive ceremony marked the unveiling of a plaque erected in the circulating library of St. Elizabeths Hospital, Washington, D. C., in honor of Mrs. Elizabeth Pearle Aull, the hospital's first librarian. Mrs. Aull had served from 1919 until her death in 1956, and had seen the library grow from a small collection housed in a single room to its present size of 45,000 books contained in a separate building.

The plaque is the only one erected in the hospital other than one commemorating Dorothea Lynde Dix, the hospital's founder. At the same ceremony the library was presented with a lacquered brass vase in tribute to Mrs. Aull, as a gift from the hospital chaplains. Hospital officials, personnel and patients attended the ceremony, as well as relatives and friends of Mrs. Aull.



Herb Garden Appeals to Elderly Patients

Working in the herb garden is particularly suited to the elderly patients who take part in the horticultural therapy program at Friends Hospital in Philadelphia, Pa. (See *This Month's Cover*, p. 1.) The garden is fragrant for patients who cannot see well, and arranged on different levels for those who have difficulty in bending. "We must consider not only the emotional behavior but also the physical condition of the patients," says the director of the gardening program, Miss Helen M. Foster, who is pictured at right above with Miss Blanche Ford, director of nursing. Last month the hospital was awarded the Pennsylvania Horticultural Society's Certificate of Merit for its beautiful grounds; special mention was made of the horticultural therapy program.

State Office Distributes Infant Care Literature

The Community Services Division of the Kentucky Department of Mental Health is mailing pamphlets on the emotional care of infants to all new parents in the state. The pamphlets are the "Pierre, the Pelican" series produced by the Louisiana Society for Mental Health. The series of twelve gives general information about providing the proper emotional climate in the home during the baby's first year.

The Division estimates that approximately 21,000 parents of first-born children will be reached this year. Their names are supplied by the Vital Statistics Division of the State Health Department.

Free Magazines Obtainable Through Postoffices

The VA Hospital at Sepulveda, Calif., obtains copies of undelivered magazines from local postoffices to add to its large patients' library. From 15 to 35 copies of some fifteen popular magazines are procured each month from eight nearby postoffices. They are collected weekly by library volunteers and delivered to the library in a station wagon. Miss Mary Jane Ryan, Chief Librarian, notes that regional and technical magazines and even some medical journals are also received by this method.

This arrangement was worked out by the VA Central Office, and all postoffices in the country were notified about the plan, so that we have had no difficulty in securing the undelivered magazines. We believe that a similar plan could be worked out for other hospitals.*

T. J. HARDGROVE, M.D.
Manager

** MENTAL HOSPITALS was informed by Post Office officials in Washington that public welfare institutions can apply for such privileges by writing to the Division of Post Office Services, U. S. Post Office Department, Washington 25, D. C. Whether the application is granted may be determined by local practices of disposing of undelivered second class mail.*

New York to Build Two New Institutions

The New York State Department of Mental Hygiene has announced plans to build two new institutions in New York City. One is a 3,000-bed mental hospital costing $52 million, to be located on Staten Island. The other is a rehabilitative school for mentally retarded adolescents with delinquent tendencies. To be situated in Brooklyn, it will give intensive psychiatric care, along with educational and vocational training, to 600 male and female patients in the 16 to 21 age group. Its construction cost is estimated at $15 million.

Soft Drink Dispensers Profit Canteen Fund

Soft drink dispensers are providing added revenue for the commissary fund at Philadelphia (Pa.) State Hospital. Nearly 50 Pepsi-Cola machines were recently installed throughout the hospital, with all profits to go to the fund. The machines, which are the 5¢ cup-dispenser type, have been placed in visiting rooms in patient buildings, in employee quarters and in certain service areas such as the laundry.

General Lecture Series Given for Patients

A series of lectures on general subjects is being given by community volunteers and staff members for the patients at the New Hampshire State Hospital, Concord. The weekly one-hour lectures are open to all patients whose ward physician authorizes their attendance. These patients may attend any or all of the series as they wish.

The dual purpose of the series is to furnish the convalescing patient with specific information that may help him readjust to the community and to reorient the longer-stay patient to world affairs, thus counteracting some of his feelings of isolation from the community. The subjects presented cover such varied matters as home nursing, gardening, taxes and insurance, world affairs, state and federal governmnt, and religion. Psychological problems as such are avoided, and the material is kept simple and direct.

The lectures held thus far have been well attended, mainly by patients from the chronic ambulatory services. The audiences seem very interested and ask numerous questions. Their general reaction to the first series will be assessed to discern what topics should be considered for possible future lectures.

DAVID J. VAIL, M.D.
Asst. Superintendent

Open House for Employees' Families Demonstrates Job Roles

By NANCY L. DORNER, Mental Health Educator
Nebraska Psychiatric Institute, Omaha

IN ORDER to stress the importance of *all* employees in the treatment program, the Nebraska Psychiatric Institute recently held a "Family Night." All of the Institute's 250 employees were invited to bring their families for a tour of the hospital and a program demonstrating the interdependent role of every department. Well over 200 persons attended, and their response was so enthusiastic that we plan to repeat the program next year.

By splitting up the "open-house" period and holding the formal program in between, it was possible to clear all areas of the hospital during one period or the other so they could be opened to visitors without disturbing patient privacy. By transferring patients to the activities area from 7:00 to 8:00 p. m., we were able to open the entire women's wing and children's unit of the hospital. Also open during this period were all non-treatment departments of the Institute.

The electroencephalograph lab ran an EEG on a volunteer employee for an interested audience. The electroshock therapy machine was set up on a dummy for purposes of illustration. Our closed-circuit television cameras were operative and guests could view themselves on the television screen. Rorschach tests were displayed for voluntary interpretation. The housekeeping department demonstrated vacuuming equipment capable of picking up liquids as well as solids. The stenographic department made available the tele-voice dictating machine so guests could play back their own voices. Every department cooperated to make the program equally interesting to the families of all employees.

Following this "touring" session, (people were allowed to wander, there were no organized tours as such) the visitors assembled in our auditorium which, with a seating capacity of slightly under 200, was inadequate on this occasion.

Dr. Cecil Wittson, director of the Institute, welcomed the guests and spoke a few words of appreciation for the fine service rendered by employees of all departments. He then turned the program over to one of the psychiatric residents who humorously described "what yesterday would have been like had just the medical staff reported to work." His remarks were most effective in pointing out the interdependency of all divisions. Following this, a panel representative of every non-medical department described their duties and their relationship to the functioning of the hospital and the care of patients.

The staff of the Children's Service presented a typical case conference describing the contribution of psychiatrist, psychologist, nurse, social worker, group worker, teacher, aide, and orderly to the treatment of the patient.

A staff member of the Community Services Division spoke to the group on the importance of employee and family attitudes toward mental hospitals and the mentally ill. Their role in community support and understanding was emphasized.

At the conclusion of this session guests were encouraged to visit the occupational therapy and recreational therapy departments and any other open areas of the building which they had missed earlier.

Patients and staff served coffee and rolls to guests at a slight charge, the proceeds of which were donated to the patient benefit fund.

The program helped to solidify employee relations (already at a very high level), and to dispel the apprehension of families of employees who had never been inside the hospital nor fully understood the duties of the employee.

Departments (continued)

First Aid Course Taught by Aides

Two psychiatric aides from the Osawatomie (Kansas) State Hospital attended a Red Cross course held at Camp Kaiser, Missouri, for two weeks last summer where they received instruction in the standard, advanced, and instructor's courses in First Aid. Their trip was financed by the Miami County Red Cross Chapter. The aides are currently engaged in teaching First Aid to employees from various departments in the hospital including the dietary, nursing, laundry, maintenance, and housekeeping departments. Eventually most employees who work directly with patients will complete the course and earn a Red Cross Standard First Aid Certificate.

Community organizations are now making arrangements with the hospital staff to have the course taught to their members. This project will help strengthen the ties between local residents and the hospital.

MRS. DORIS TROBAUGH
Director of Nursing Education

Patient Efforts Extend Donation to Library

When a local church club donated $50 to the library of Eastern State Hospital in Knoxville, Tenn., recently, the hospital felt the library's biggest need was for magazine racks and a book cart. Since the donation would not cover the purchase of those items, however, the money was used to buy the materials and the items were made by patients in Industrial Therapy. The church club was so pleased with the use made of its donation that it plans to contribute another fifty dollars.

Patients Stage Musical For March of Dimes

Some fifteen mentally ill patients at the Osawatomie State Hospital in Osawatomie, Kansas, staged a musical comedy to raise funds for the annual March of Dimes. The idea for the show is an outgrowth of the newly formed patient government whose members are encouraged to make decisions for themselves under minimal supervision. The very amusing script was conceived and written by the patients themselves and involves a school classroom, teacher-student relations and musical numbers.

As one of the residents of the town of Osawatomie (population 4,500) said, "We have had a large state hospital nearby for a long time but this is the first time that we have seen a musical program staffed by hospitalized patients, assisting the community in a drive for funds for the March of Dimes." The one hour show was well attended by the townspeople of Osawatomie and hospital employees. Over one hundred dollars was donated to the March of Dimes by the audience.

A few days later the patient cast put the show on at nearby Topeka State Hospital and performed for that hospital's patients and staff. After the play, which was enthusiastically received by a packed house, the patient cast from Osawatomie was entertained with a dinner-dance by a group of Topeka State Hospital patients.

EUGENE J. PAWL
Personnel Director

Dietary Internes to Train at Oklahoma State Hospital

As part of their one-year dietary internship, nine women will spend two weeks of training at the Central State Griffin Memorial Hospital in Norman, Oklahoma. The women, who hold B.S. degrees in home economics, are from two general hospitals in Oklahoma City. They will come to the state hospital, two at a time, to learn the special dietary needs and food service procedures of a mental institution. A two-day orientation session was held at Central State for the group three weeks prior to the first training period.

Book Review

MENTAL ILLNESS—A GUIDE FOR THE FAMILY, **(Revised Edition) By Edith M. Stern. With a foreword by William C. Menninger, Harper Bros. 95 pp. + xix. Price $2.50, *hard cover. ALSO National Association for Mental Health. 95 pp. (no foreword).* Price 50¢ paper. ($40 per 100 copies; $300 per 1,000.)**

Ever since its first appearance in 1942 this book, originally written in collaboration with Dr. Samuel W. Hamilton, has brought understanding and comfort to thousands of persons whose relatives had suffered or were suffering from mental illness. Now, thoroughly revised by Mrs. Stern, it has been reissued in an inexpensive form designed for even wider distribution than before.

In fact, in nearly one half of the States (and, we hope, in more soon) plans are in operation, under the sponsorship of local and State mental health societies, to make available the N. A. M. H. edition to the family of each patient admitted to a mental hospital. A more valuable public service it would be hard to imagine.

Starting with a general discussion of sound attitudes toward mental illness, Mrs. Stern considers such questions as the desirability of hospital care, the question of private versus public hospital, admission to the hospital, the nature of hospital care and treatment, visits, the family's and friends' attitudes toward the discharged patient, and what the public can do (volunteer services, support of mental health societies, and so on). Along the way, she very thoroughly demolishes some of the "popular delusions" regarding mental illness and hospitals which so plague families and impede the patient's progress. A brief glossary of psychiatric terms concludes the book.

It should not be thought that the patient and his family are the only ones who will benefit by perusal of this little volume. The development of understanding which the book should help to achieve will make much easier the path of the hospital personnel in answering the numerous questions for which anxious relatives are seeking answers.

Mrs. Stern has rendered a signal service to the mentally ill and their relatives, and the National Association for Mental Health deserves much praise in making the book generally available.

WINFRED OVERHOLSER, M. D.
Washington, D. C.

Inservice Training Workshops for Nursing Home Operators

By WILLIAM S. SIMPSON, M.D., Clinical Director
and ROBERTO D. MOULUN, M.D., Staff Psychiatrist
Topeka State Hospital, Kansas

THREE YEARS AGO the Topeka State Hospital started a program to raise the level of care given to selected elderly patients who are paroled to nursing homes and boarding homes. These patients have received maximum hospital benefit and mostly need kind custodial care. This plan has been our answer to the problem of steadily increasing numbers of patients over 65 in the hospital—about 20% of the admissions plus those who were admitted at an earlier age and have grown old in the hospital.

Although the patients paroled to the nursing and boarding homes are out of the hospital domain, they are to some extent still the hospital's responsibility. Thus it was felt that the hospital should offer training to the operators of the homes so that they could give better care to the hospital patients assigned to them.

The training course was worked out by the superintendent, chief nurse, chief social worker, chief occupational therapist and others, and was approved by the State Supervisor of Licensed Nursing Homes. It is open to any operator or employee of a boarding or nursing home in Kansas—not just those who have hospital parole patients.

The first group of six trainees arrived at the hospital on January 11, 1954. Since that time over 300 nursing and boarding home operators and employees have taken the Workshop course, which is held every other week.

The Workshop begins on Monday morning, with a daily schedule of 7:00 a.m. to 3:30 p.m., and ends Saturday noon. The trainees receive no pay but get room and board in exchange for the incidental duties they perform.

The curriculum includes a one-hour lecture by a psychiatrist, on the general problem of aged patients with emphasis on symptomatology, and general principles of treatment; and another hour on the handling of disturbed patients. The social worker spends an hour at the beginning of the course explaining the organization of the hospital and outlining the Workshop curriculum; a second hour later on is spent in discussing how the hospital, the boarding and nursing homes and the county welfare offices work together on the placement of patients, discharge planning and similar procedures. A one-hour lecture is given by each of the following specialized personnel: a nurse, on nursing care of the aged; the dietitian, on feeding of the aged; the chaplain, on the significance religion has to elderly patients and ways in which religious services can be used in the nursing homes; the fire marshall, on fire prevention; and the chief of volunteer services, on how to use community resources. The lectures are informal, with considerable time allowed for questions and discussions.

Routine Eases Anxieties

The trainees spend approximately four hours a day on a female senile ward. Each is assigned to one ambulatory and one bed patient, and is supervised by an experienced charge aide. This causes some dissatisfaction among new trainees – because they "know all about" routine care of elderly patients—but we feel that working their accustomed routine makes them feel more secure and relieves much of their initial anxiety about working with mental patients. They learn much more than they expected simply by observing the work of the charge aide on the training ward. She is a warm, kindly, mature woman with infinite patience, and many of the trainees reported at the end of the course that if they had not learned anything else their observation of this particular aide's work would have been worth the time spent at the hospital.

The trainees also spend about three hours daily working with patients in occupational therapy, both in the O.T. shops and on the wards. The time devoted to this activity was increased after the first Workshop, since the trainees showed so much interest in the possibilities of using occupational therapy in their own institutions.

During the week the trainees attend a one-hour ward patient government meeting on an open ward. Here they see that even chronic psychotic patients can benefit from a measure of self-government. The experience serves also to make the trainees more realistic about this type of patient. A number of trainees, in their short stay at the hospital, tend to become overconfident of their abilities to manage mentally ill patients. The impressions they receive in brief contacts are superficial and do not reveal the underlying pathology. By spending an hour observing a group of psychotic patients trying to communicate with one another, however, the trainees are made more aware of the patients' less obvious difficulties.

The Workshop closes with a one-hour session in which any remaining questions are answered. The trainees record their reactions to their learning experiences and are invited to suggest changes in the curriculum. At this time each receives a diploma certifying completion of the training. A number of the trainees subsequently arranged to take one or more of our patients into their nursing homes.

Workshop Attendance Made Home Licensing Requirement

Verification of our Workshop plan's value comes from the Department of Licensed Nursing Homes, whose representatives regularly inspect the nursing and boarding homes in Kansas. The inspectors have noticed a perceptible improvement in the care provided to patients in nursing and boarding homes whose operators and employees have been trained in the Workshop. The State Supervisor of Licensed Nursing Homes has been so impressed by the favorable influence of the Workshop program, in fact, that the attendance of nursing home operators at the Topeka State Hospital Workshop has been made a requirement for the licensing of nursing homes.

PDQ: PATIENTS' DISCHARGE QUARTERS

The organization and staffing of a self-governing socialization ward

By JOHN F. MULDOON, Ph.D., Coordinator of PDQ Ward
Veterans Administration Hospital, Pittsburgh, Pa.

THE PURPOSE of hospitalization is the treatment, rehabilitation and socialization of patients. It should be the concern of the hospital staff not only to interrupt the pathological processes of illness but also to strengthen patients so that they can return home better able to cope with the stresses of everyday life. Unfortunately, we have given too little attention to our strengthening function, perhaps forgetting that an ex-patient will be a patient again if we have not in some way improved his ability to dispatch his emotional problems centering about his interpersonal relations.

It is the purpose of this article to specify some aspects of socialization and to report on how we are attempting to fulfill them at this hospital.

One of the goals of socialization is to undo the effects of hospitalization. The patient preparing for release must unlearn certain dependent habits that have been fostered by his treatment; he must cease to depend on others for his medication, the care of his clothing, his necessities and his recreation. In other words he must regain a feeling of adequacy by which he prides himself on his ability to stand on his own two feet. But such a sense of sufficiency is not easily reestablished after long months, perhaps years, of benevolent confinement.

The difficulty of the patient's transfer from the hospital to the community has long been recognized. To overcome it, specialized programs such as outpatient treatment, member-employee status, and foster-home placement have been established. And recently, we have heard more and more about the "halfway house" and have seen the establishment of two or three such programs. But for the great majority of patients no such assistance is available. The need still remains for a broader rehabilitation and socialization program that not only carries the patient to the door of the hospital but also accompanies him into society, lending him support, encouraging and directing, until he stands in the community as a self-respecting and respectable citizen.

Special Program Set Up to Ease Transition

At this hospital we have established, as an integral part of the overall program, a special program in which we have attempted to meet specifically the transitional problems and anxieties of the patients. Our program is called Patients Discharge Quarters, giving a new meaning to the expression "PDQ."

The program, conceived by Lee G. Sewall, M.D., Manager of the hospital, has a two-fold goal: (1) the undoing of the patient's unrealistic dependence on others for his major decisions and cares; and (2) the extension of the supportive, but no longer controlling, arm of the hospital to the patient as he begins his gradual return to the community. Patients spend three to six months on PDQ.

Diagnostic classification is not taken into consideration in the selection of patients for this program. All who elect to join PDQ are men who have demonstrated their capacity for ground privileges but are still considered unprepared for early discharge. During the initial interview, an effort is made to assess the man's motivations and to estimate to what extent he could profit from the social experience. Patients have been in hospitals for varying periods—the present range is from 12 months to 25 years. Most have repeatedly failed to make a satisfactory adjustment to community living during their present or previous periods of hospitalization.

Administratively, our 40-bed ward is organized to resemble a hospital as little as possible; emphasis is placed on freedom and responsibility. We have attempted to bring community life into the hospital so that some of the stresses of returning to the community can be faced in the supportive atmosphere of the hospital.

All patients on PDQ not only have ground privileges but are free to leave the hospital grounds without a pass, their identification card being sufficient. They are encouraged to make full use of this privilege, to visit families and friends, to look for employment, and to meet social and financial needs as they see fit. As a group, they are responsible for the administration of the ward, the establishing and enforcement of regulations governing their group life.

The patients' responsibility for the maintenance of the ward is extensive as there are no psychiatrists, nurses or aides assigned to the ward. So the group, through election and delegation, is responsible to itself and to the hospital administration for the operation of the program. Each patient has to care for his personal needs, to secure his own medications at regular intervals, and also to take care of the general needs that make up community living.

The only professional person assigned to the ward is a psychologist, called the Coordinator. His main duties are to oversee and give general direction to the operation of the ward and to evaluate the individuals' progress through their rehabilitation. He spends little time with any individual patient, preferring to refer ward members to therapists for individual treatment so that no patients become favorites by absorbing a considerable amount of his time.

His time is reserved predominantly

for group activity and for such assistance as is given to all members regardless of their individual difficulties. He oversees the election of the Administrative Council, arranges for the patients' activities, communicates frequently with the medical consultant responsible for medications and with the psychotherapists, counselors, and social workers who are active with the patients in psychotherapy or discharge planning. Much of his time is spent preparing patients for employment through hospital work assignments and helping patients to formulate employment plans. Hospital assignments are evaluated regularly with both patient and supervisor so that the patient can be counseled about his progress.

Council Reviews Suggestions

In directing the program, the Coordinator arranges for a weekly meeting, brings to the attention of the group information he has received relevant to the ward functions, and suggests activities or problems to which the group can give its attention. However, all of the Coordinator's suggestions are subject to review by the patients' Administrative Council, which has the power to modify or reject them.

It is of prime importance that group interaction and individual participation be kept at a high level. This goal is furthered by the Coordinator's unwillingness to make decisions concerning the group; it is understood that he will act unilaterally only regarding individual emotional difficulties and discharge planning. All other decisions are turned over to the group. The individual's responsibility for himself and his companions cannot be readily abdicated. In addition, the Coordinator suggests activities geared to promote interaction and responsibility. For instance, during the last holiday season, the group voted to act upon the Coordinator's suggestion that they entertain a group of underprivileged children. As a result a party for 60 children was planned, financed, and executed by the members of PDQ.

As can be imagined, patient reaction to PDQ is mixed. Some patients are jubilant about it; they react to the program as if it were a personal challenge to demonstrate that they can get along without the hospital staff. Others are more cautious; one recently expressed his ambivalence by saying, "I don't know if I want to stay on PDQ. Here you have to be good; you have to think about all these other guys. If I go back to a locked ward, I don't think about nobody; they just think about me." Still another, correctly evaluating the situation when he was transferred to the ward, asked, half timorously and half angrily, "Who will give me my clean linen each day? To whom will I go when I can't sleep?" The latter patient saw correctly that there would be no one handy to give him his towels each day, no one to give him his evening APC and his midnight sedative. Months later he admitted that he had "never been so scared in all my life" and didn't sleep the first few nights on PDQ.

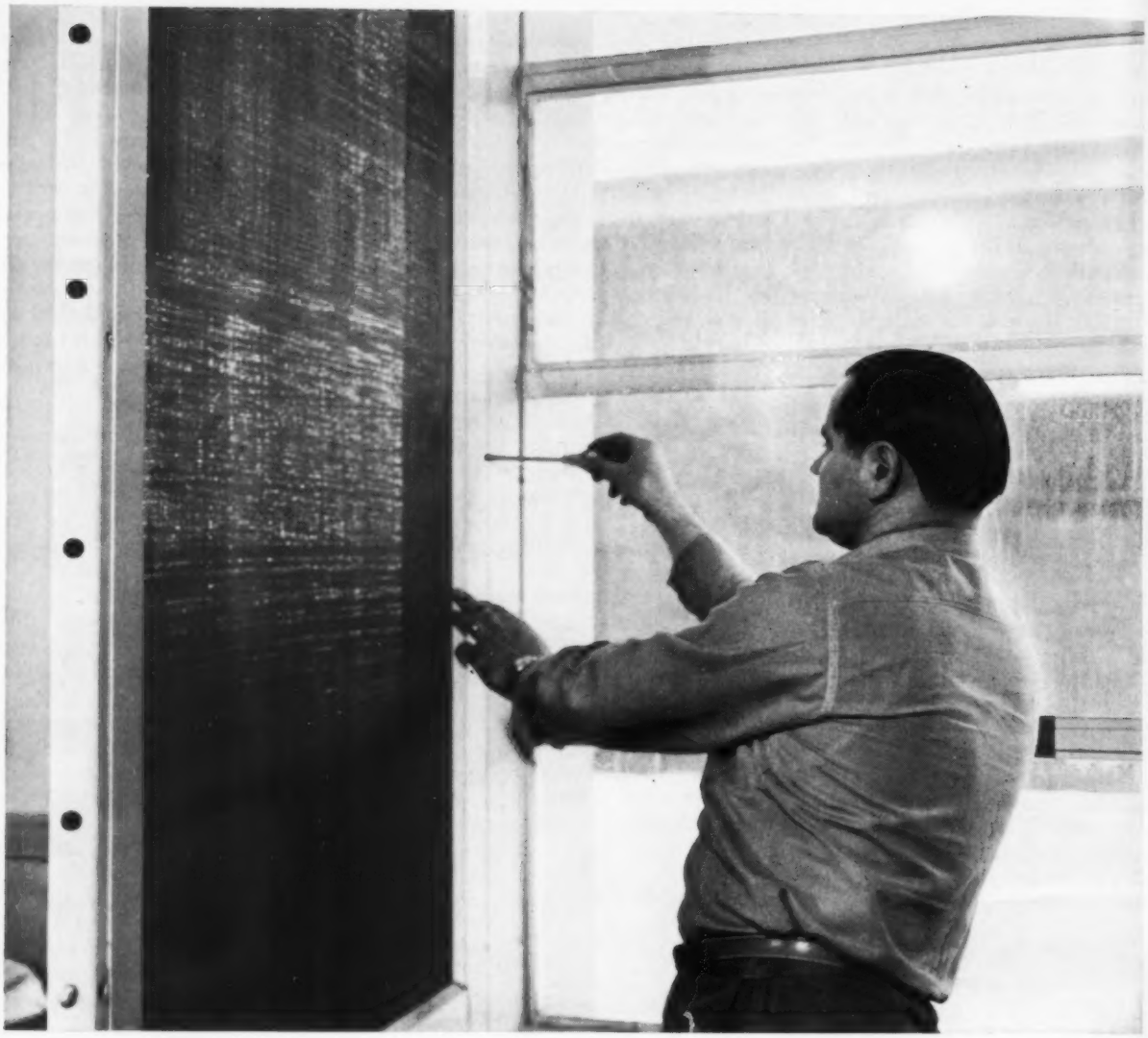
Members of the Administrative Council, which is elected by the patients on PDQ ward, meet each week with Dr. Muldoon (at right, in dark suit) to discuss ward plans and to consider his suggestions.

Initial Results Promising

The program is not yet a year old and so far the results have been encouraging. Initially, there was some concern about leaving the patients unsupervised from 4:30 P.M. until 8:00 A.M., but the manner in which the patients have conducted themselves has come up to our highest expectations. There have been difficulties, but they have been infrequent. The Chief Guard of the hospital, whose staff probably sees more of the patients after hours than anyone, has remarked that the patients have given him little cause for concern.

After a month on the ward, many begin to look for employment or training opportunities in the city. Optimally, discharge follows after employment has been secured and housing arranged. PDQ is so flexible that patients can meet practically any commitment to an employer. Recently a patient who had attended barber school for four months, decided to take living accommodations near the school for the duration of the course in order to become accustomed to this new living routine before discharge.

Perhaps we are still in the first fervor of our reaction to this new program. But notwithstanding our high expectations of this new adjunct to treatment our experience has demonstrated that such a program is administratively feasible in a large, neuropsychiatric hospital. Our impressions of patient reaction and adjustment to PDQ support our hopes that this program is a step toward helping patients lessen their exaggerated dependence on others and to minimize the strain of sudden release from the hospital.



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Sociopetal Building Arouses Controversy

Following the publication of Dr. Humphry Osmond's article, "Function as the Basis of Psychiatric Ward Design", in the April issue of MENTAL HOSPITALS, together with the architectural presentation of Mr. K. Izumi, the Editor invited a group of distinguished psychiatrists and architects experienced in mental hospital design to comment upon the paper and architectural plans.

These comments are published in this month's Architectural Supplement in the hope that others will be encouraged to submit what Dr. Bay calls "fanciful" ideas, which will stimulate us all into taking a new look at a problem as old as hospital psychiatry.

Comments from Psychiatrists

DR. OSMOND and Mr. Izumi have proposed an exciting new concept in mental hospital design. It is based on the hypothesis that structure determines function and function can determine structure.

There is little question that in some schizophrenics there is distortion of perception and changes in mood and thinking and that from these may be derived certain requirements for patients. Everyone will concede that mental patients must not be overcrowded or overconcentrated and that there is need for adequate staffing. It seems rational to provide a path of retreat and some privacy, and encouragement to form relationships with others.

I would heartily endorse the principle of erecting such a building as Dr. Osmond and Mr. Izumi propose so that there can be experimentation with this radical new form. There is grave doubt, however, whether the building in itself can accomplish all of the results. Properly trained personnel in sufficient numbers can develop intimate relationships with individual patients and with groups of patients in a variety of ward buildings. It would seem possible to develop close inter-personal relationships in other settings rather than construct a building to achieve this end.

WALTER E. BARTON, M.D.
Superintendent
Boston State Hospital, Mass.

I HOPE it is more than my affection for Dr. Osmond that makes me disagree with some of his critics. They say his ideas are wild. I would rather call them "fanciful." I think there is room for an *awful* lot of imagination in the special area of mental hospital architecture.

I can understand that some of Dr. Osmond's opinions—couched in his picturesque similes—are very disturbing to those who *think* they have built very fine buildings of their own. I think such people need to be shocked. Personally—I'm ashamed of some of the buildings I'm responsible for!

I'd do anything I could to encourage people to listen to Dr. Osmond. After all—he doesn't ask anybody to *believe him*—he only asks that they experiment and try to find out for themselves what will work best.

ALFRED PAUL BAY, M.D.
Superintendent
Topeka State Hospital, Kansas

WHILE we found Dr. Osmond's report extremely interesting and challenging, we would like to comment on several of his conclusions which we feel are based on unproved assumptions.

Under "Disturbances in Perception" he states ". . . groups of four to eight people . . . will give each other empathic support and lessen fear."

Depending on the individuals involved, these four to eight people may well irritate each other in close physical relationships. Differences in intelligence, social background and race will be important, for instance.

"The ample provision of clocks . . . is necessary . . . ," he says. Too many clocks can produce additional confusion in schizophrenic patients.

Again: "The coarseness of institutional clothing and the lack of pleasantly-textured fabrics . . . have undoubtedly been harmful to the mentally ill." On the other hand, plush interiors which are foreign to the patients' experience can make them quite uncomfortable.

While he notes that changes in the perception of one's own body can be detrimental, he does not add that observation of the bodies of other persons, especially with regard to sexual conformation, can likewise be disturbing.

Under "Changes in Thinking" Dr. Osmond suggests that "Mirrors in bedrooms and bathrooms can help to remind one who one is." Too many mirrors, and especially mirrors with distortions, can be very disturbing.

In the section entitled "Rules Deriving from the Patients' Needs" he states: "Some animals, if forced to live in overcrowded conditions from which they cannot escape, will die." It is also true that many animals prefer to live in close contact with each other. We should not confuse overcrowding with design. Either overcrowding or isolation can be a fault of *any* design.

Dr. Osmond says that "there is evidence that groups of four to eight people are especially liable to form beneficial, supportive and constructive relationships. . . ." Agreed, but patients should be allowed a choice of associates.

He further states "The psychotic person needs surroundings which allow and encourage him to make the sort of choices which we all make regarding everyday matters—food, clothing, entertainment. . . ." Unfortunately, public funds cannot be made available in sufficient amount to permit each individual patient to make such choices, and too, some patients may be too confused or disturbed to exercise choice.

The line drawings submitted by architects Izumi, Arnott and Sugiyama obviously are incomplete. Certainly special provision for additional activities must be made and such spaces and utilities must be provided by ready access for maintenance and repair units. No provision is apparently made for food service and dining areas. Occupational therapy, industrial therapy and similar activity programs seem to have been excluded. One suspects this interesting design can be improved with additional study and attention.

ADDISON M. DUVAL, M.D.
Assistant Superintendent
SAMUEL B. WILSON
Chief Engineer
St. Elizabeths Hospital
Washington, D. C.

AS HYPOTHESES for testing, the ideas presented by Dr. Osmond are interesting and worthy of testing in a properly staffed experimental set-up. It is certainly conceivable that the arrangement of the room or the furnishings may have beneficial effects on the patients, but the research in this area remains to be done. His assumptions are not altogether logical. He describes at length the differences in perception and conception found in schizophrenic patients and then makes judgments of patients' reactions on the basis of the mental activities and opinions of the non-schizophrenic psychiatrist or architect.

Mr. Izumi has created a plan to carry out the hypotheses set forth in Dr. Osmond's paper. As an experimental project this is laudable, but it should be considered as such and carefully tested, as Dr. Osmond has pointed out.

In Massachusetts we have some round wards that were built in 1900 or thereabouts, patterned after some hospitals the superintendent had observed in England. The situation, however, seems to differ importantly from Dr. Osmond's round ward, as the purpose was to have the nurses and attendants and the patients mingling in the central day space. The nursing service is concentrated in the hub, thus enabling full observation at all times of all the patients in the beds scattered around the rim of the wheel. These wards have never been popular with either nurses or patients, at least not in modern times, and are presently used for dormitories by patients free to move into other areas of the hospital during the day.

It is not altogether clear to me what advantages are to be found in the semi-circular arrangement of the wards as compared with the roughly sketched rectangular one outlined in his illustration number four. I believe the problems and costs found in circular construction should be justified by some demonstrable advantage which I fail to see in the diagrams. Perhaps further study or further explanations by the author would make this obvious.

One would likewise hope that they do not intend to use curved glass windows to further increase the expense, as the cost will already be increased by the necessity for using circular forms for concrete, brick, and stone surfaces.

This is not to say that architectural design should be considered only in terms of cost, but certainly anything that adds to the cost should be justified by some demonstrable improvement.

JACK R. EWALT, M.D.
Commissioner
Department of Mental Health
Boston, Massachusetts

DR. OSMOND'S ESSAY is a vitally important one—and deserves all the earnest thought which has obviously gone into it. One cannot quarrel with his three basic assumptions which are beautifully developed in the body of his paper. He places proper emphasis on providing a spatial arrangement in which the staff can give the greatest care to the patients while permitting the patients the maximum opportunity to help each other. Many of Dr. Osmond's other suggestions calculated to improve the patients' perceptual status—such as provision of clocks, calendars, ample space, good clothing, etc.—will find universal approval.

It is, however, in this very sphere that one of the basic contradictions arises. Dr. Osmond states:

"Other results of these perceptual changes are: (a) Changes in visual perception so that *familiar* surroundings seem changed; the uncertainty which this generates may be frightening. Experimental evidence (and we have not nearly enough of this at the moment) suggests that small, *reassur-*

ing, easily encompassed spaces are desirable." (Italics mine.)

If *familiar* surroundings seem changed to the schizophrenic, it would seem appropriate to construct a hospital which would be as "familiar" and "reassuring" as possible. It is doubtful if Mr. Izumi's semi-circular solution, provocative as it is, will be either familiar or reassuring to most psychiatric patients. Most patients in our Western culture (and, for that matter, most non-patients) when asked to draw a house will draw the conventional peak-roofed dwelling which has served as a symbol for home, comfort, and security for many centuries. The flat-roofed, box-like structure of the contemporary architect has not yet penetrated the symbolic inner life of the average man. The even stranger design of the semi-circular building with multi-leveled ceilings may be difficult for the patient to grasp. The hotel-like hospital, "sociofugal" as it may be, is still a comprehensible and familiar model to most people.

It has been of the greatest interest to observe how psychiatric patients, even if housed in conventional units or antiquated wards, will, somehow or other, find a way of functioning on the three levels of association referred to by Dr. Osmond. If a patient sleeps in a 50-bed dormitory and spends his days in a huge dayroom, but has a need for solitary retreat, he will find it even if he has to crouch by himself in an obscure corner. When patients hunger for the intimate group association, they will "agglutinate" in clusters of 3 to 6 in someone's single room, a double room, an alcove, or even in a section of a corridor. Most patients will prefer this to the large dayroom which usually does not provide for interaction on a meaningful level.

"Reassuring Familiarity" Needed

If Mr. Izumi's solution could be provided with some degree of "reassuring familiarity," and still retain the ingenious spatial relationship between personnel and patients as well as between the patients themselves, I believe he will really have something. It must be remembered, of course, that psychiatrists of good will have been able to do excellent work with patients even in the "monstrous and unsatisfactory" hospitals to which Dr. Osmond alludes.

I hope that Dr. Osmond's principles and Mr. Izumi's bold design will bear fruit. Certainly their work should provoke the widest possible discussion, leading to refinement of a grossly neglected subject. Perhaps we have here a glimmering of the shape of things to come . . . the psychiatric hospital of tomorrow!

ZIGMOND M. LEBENSOHN, M.D.
Washington, D. C.

HOW ABSURDLY RIGID and unimaginative our present psychiatric hospitals will look to a future generation! How poorly adapted many of them are to a modern concept of the restoration of mentally ill patients to health. Could we, by taking thought and talking with architects, plan better even now?

Dr. Osmond sees the illogical, the inappropriate, the self-injuring elements in our present habits of architectural thought. His gropings for new and better forms, his suggestions for improvement will certainly not be the last word. But they are an effort in the right direction. This article is a fresh breeze of new thinking in an area which is generally left to the architects. They know too little about our needs from scientific knowledge or practical experience to do the dreaming which is their function, and which has brought us beautiful cathedrals, beautiful libraries, beautiful banks, but not truly beautiful and functionally ideal psychiatric hospitals.

KARL MENNINGER, M.D.
Topeka, Kansas

Comments from Architects

I FEEL that Dr. Osmond's paper is well reasoned, and I agree wholeheartedly with his conclusions. Communal living is difficult for most people, and should be particularly so for psychotics. I know from personal experience in the armed service that nothing is so highly prized as privacy, and so difficult of attainment. All animals, including the human, instinctively seek a retreat when they are hurt, and it is reasonable to suppose that the mental patient would desire to shut himself off from the people from whom he is disassociated, and who he often imagines are the source of his trouble.

As in convalescence the mental patient approaches normalcy, habits of gregariousness should reassert themselves and the pattern suggested by Dr. Osmond of progressing from a limited number of people to a large group is most logical.

Mr. Izumi's sketches indicate a solution of this concept in a circular plan. While this constitutes a theoretical solution of the problem, I cannot help but question the practicability of the circular form, as it is difficult to roof with conventional framing methods and because most of our present materials and furniture are rectilinear in form. It has been our experience that such buildings are expensive to construct. The plan is reminiscent of the old roundhouse type of prison which was built thirty or so years ago.

I also question how the small group area is to be lighted. If it depends on clerestory windows for natural lighting, another complication is introduced into the structural pattern, and the light itself is none too pleasant. Furthermore the people using this small group area do not have any windows out of which they can look.

It would seem to me desirable to explore the possibility of developing a rectilinear plan. Such a plan could probably be worked out with two small group areas on each side of the large group and three retreats on one side of each small group. In this way each of the small group areas would have outside exposure and the difficulties of circular construction would be avoided.

H. COLEMAN BASKERVILLE, A.I.A.
Baskerville & Son, Hankins & Anderson
Architects and Consulting Engineers
Richmond, Virginia

AT A TIME when the trend in the design of facilities for the treatment of most psychiatric patients is toward providing a normal environment, i.e., more open cottages, less security, greater responsibility (with less supervision) placed on the patients to exert self-control and behave in a socially acceptable manner, the proposed scheme would seem to indicate a return to the rigidly controlled traditional mental hospital environment. There is no denying that interrelationships between people exist (in normal, as well as hospital situations) and that these are important and are manipulated by the staff to the benefits of the patient, but this is best accomplished in a normal, as opposed to a strange environment. Medical staffs are constantly pleading for "homelike" rather than institutional surroundings in which to treat patients.

While the attempt was made in Mr. Izumi's plan to provide a sitting space for every four single bedrooms, this space also opens directly into the group activity area. The plan also would seem to place undue emphasis on the requirements of each dormitory unit to include group-activity areas and to suggest that the most important relationships may occur within the dormitory areas. In most treatment programs great effort is made to get the patients out of dormitory areas during the day and into other areas for useful work, recreation, socialization and relaxation, where patients may be brought together in a constructively stimulating environment of the desired activity.

The most successful programs which I have seen, for most patients other than acutely physically ill, placed less emphasis on dormitory needs and more on the needs of patients during their waking hours. Emphasis was placed on activities and these activities were carried on outside of the dormitory areas. In the design of dormitory areas emphasis was also placed on the need for a variety of bedroom sizes, from one to four beds to a room, since it was maintained that not all patients feel comfortable in a single room and may benefit by the presence of other patients.

The greatest difficulty today in the design of facilities for the treatment of psychiatric patients is to obtain adequate definition of the particular problem. In general we still design only for "mental patients". If design is to keep pace with modern treatment techniques, it must first be recognized that the needs of patients of the different classifications or degrees of illness must be determined. Unless the states (having accepted the responsibility for the care of psychiatric patients) stop and analyze the needs of the variety of patients who require treatment, it is hardly possible to do other than design more or less typical buildings into which all types of patients are placed.

The better organized programs have provided services in medical buildings for the emergency, acutely ill patient; community clinics and day and night care services; special hospitals for alcoholics and for psychopaths, as well as special building types for the variety of services required in mental hospitals. These include special buildings for the reception and care of new, ambulant, acutely ill patients; open cottages for convalescent patients (before, during and after a program of treatment), coeducational dormitory buildings in which men and women may live in the same facility, facilities for disturbed, geriatric and acutely physically ill patients, and central facilities for work, recreation and socialization.

Normal Settings Urged

Special reference has been made by Dr. Osmond to the problem of planning for the schizophrenic. The theme of the Ninth Mental Hospital Institute was "The Hospital Atmosphere." In the discussions much was said about the "therapeutic community," normal social settings and so on. The February 1957 issue of MENTAL HOSPITALS reported on these discussions, and Dr. D. J. Plazak, one of the discussants, pointed out that programs for patients which allowed them to assume roles similar to those they had outside of the hospital led to more speedy recovery. This increased recovery rate applied to acutely ill schizophrenics as well as to patients characterized by "behavior disorders" (page 11, 3rd column). The total report of the Institute contained much *practical* material on how to improve the environmental situations for patients.

Each problem has a different requirement, so that the facilities will vary in design. The custodial building in which it is intended that patients will spend most of their time is not adequate for modern treatment programs.

ALSTON G. GUTTERSEN, A.I.A.
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DR. OSMOND'S ARTICLE is the first example I have seen of an attempt to explain the effect of environment on mental patients and the need for creating surroundings that at least may not be harmful to them and possibly may be helpful in effecting their cure.

I am not able of course to judge whether the writer of the article is correct in his assumption as to the effect an institution may have on a patient, what in other words may be helpful and what harmful, but as an architect I am sure that he is correct in what he maintains must be known or assumed before a building can be properly planned.

Dr. Weckowicz' notes are likewise very revealing. Anyone who thinks it is unimportant not to tell an architect that the space perception of schizophrenics is different from that of a normal person doesn't understand how good buildings are planned.

Mr. Izumi's design analysis and his plans are interesting and at least show one solution based on Dr. Osmond's assumptions. I have always felt there are many objections to the curved wall building and not just because it is expensive. For mental patients it may not be important but ordinarily it seems to me a mistake to plan a room where the bed is so placed that anyone occupying it has to have his back to the window or has to face the window. It would certainly be far from ideal in a general hospital. With his back to the window the patient cannot see out, and to face it is very uncomfortable. As I say, this may not be important to patients who are not often in bed in the daytime.

Another objection I have to the plan is the lack of privacy of the toilet, which in a sense is out in the middle of the group area.

Altogether, however, there is a certain amount of ingenuity to this plan and at least as a diagrammatic solu-

tion to Dr. Osmond's proposals it is both interesting and original.

SLOCUM KINGSBURY, A.I.A.
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I AM PLEASED with Dr. Osmond's discussion of programming a psychiatric hospital. He is giving the architect the kind of information that is required. Where he says, however, that "Structure will determine function, unless function determines structure," he probably means that function must determine structure, otherwise structure will dictate function.

I am sure that Dr. Osmond is restating the philosophy of Louis Sullivan, the father of contemporary architecture, when Sullivan insisted that "form follows function." I think that in his "summary" he is suggesting that a psychiatric facility must be designed from a community planning point of view. I feel very strongly on this subject.

I am interested in the concept of the round plan suggested by Mr. Izumi. I think with further development he can arrive at a very good solution. However, I have some questions which I would like to ask.

Starting from the outside of the circle and working in, I wonder if these single rooms have to be as small as he suggests. I suspect that if these rooms were a little more generous in size, it would help to reduce the patient's tension as Dr. Osmond desires. I am suspicious that the architect was running out of circumference to the circle and talked himself into believing that very small rooms are more desirable.

Whether patients should be in groups of four is something that the psychiatrist should answer. However, I have a feeling that his small group area is not a pleasant place. For one thing, any activity going on in that area would be interrupted by patients going to and from their private rooms, to the toilets and baths, and to the large group area. Furthermore, it is impossible to light this area with natural light, except what can be borrowed through the open doors to the patient rooms and from the large group area. He may have in mind using some kind of skylighting, but to me that doesn't make a very pleasant climate.

Furthermore, I question the use of private toilets and private baths because they must be very difficult to supervise. It appears that these facilities would have to be locked when they are not in use. Nor does it seem very desirable to have these facilities directly off of the small group area. I think it is rather arbitrary to say that these patients will be groups of four. Perhaps it would be better to provide more flexibility in the size of this small group area so that different sized groups could be accommodated.

I think the large group area is much more satisfactory. I can see that it would be a very pleasant place to play games, visit, etc. I am fascinated by the large glass area which, if given proper orientation, could be very desirable.

I wonder about the movable nurses' station. From a control point of view, it is certainly well located. However, I cannot justify its having the most important location in the entire facility. It is also my understanding that nursing stations have to be provided with some mechanical and electrical facilities and to make a movable unit presents some complications.

I would like to see Mr. Izumi try a scheme which would place the small activity areas along the circumference where they would get natural light. These could be located between pairs of single rooms. I realize this might reduce, or even eliminate, the natural light for the large activity area. However, I think that skylighting or clerestory lighting would be more acceptable there than in the small activity area. If private toilets are more desirable than gang toilets, they could be between the patient's room and the large activity area. I further suggest that the storage area be located closer to the nursing station and be an inside room.

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DR. OSMOND'S CHALLENGE to the architectural profession, that they may learn from psychiatrists, sociologists and anthropologists how to develop a truer understanding of the nature and problems of mentally ill people, and thus be able to build well for them, is a welcome and timely one.

Mr. Izumi, in his plan, has given a physical form for many of the interesting ideas put forward by Dr. Osmond. The provision of a nursing unit for only 24 patients appears in itself to be an important advance. The individual "retreats" where a patient may be alone, the small group areas where he may be with three or four familiar people, and the large group area where he comes in contact with all the patients, appear to be a logical outgrowth and a clear architectural statement of the facts presented by Dr. Osmond; this plan also has the great virtue of eliminating corridors.

Mr. Izumi's plan is a "radial" one. This is of particular interest to me since in 1950 I developed a nursing unit plan employing the same basic principle. This was for the care of acutely sick medical and surgical patients. Here I was concerned in getting the best patient care by making it as convenient as possible for the medical and nursing staff to provide for their needs; hence, the placement at the center of a "core" of utility and treatment facilities and the virtue of short communications for the staff.

Mr. Izumi's requirements are altogether different and, as he himself clearly states, the principal factors that led him to a radial plan were three: First, the progression of areas required, from the retreats to the large group areas; second, the elimination of corridors; third, the development of what Dr. Osmond calls a centripetal building. These things he has achieved and the logic and geometry of his plan are instantly apparent to the eye.

For me the plan raises an important question. We have here in the building as it is in mass on the ground and in its interior spaces, a physical environment quite unfamiliar, hard to comprehend and unlike home. May this unfamiliarity be a frightening thing to people already confused? I believe that the familiar forms and the physical surroundings which condition our senses in daily life are of major importance and need to be preserved and carried over into the life of the mental patient in the hospital. As the patient recovers he should have close to him his relatives and friends so that they may help him in the process of reintegration into society. It becomes important for the visiting friends as well to find those they care for in surroundings familiar to them.

Such a concert is best established in a community setting. With the growing importance of out-patient care (day clinic), the relation to the community and the physical forms of the institution also become increasingly important.

Dr. Osmond writes of the techniques of airplane designers and of experimental buildings. I should like to see tried for mental care a group of small buildings, each nursing unit a "home" where a group of patients live together. Here the scale of living room and bedrooms would be familiar and the space and routines designed to foster easy interpersonal relationships and to build the responsibilities so needed for rehabilitation. The relation to major group activities could be articulated to be reminiscent of home and community life, with gardens and outdoor recreation spaces planned for a sense of freedom. The whole complex should be so planned as to be a part of a live and healthy community which it would serve along with the general hospital. Such a complex would require more space and larger staff than a compact building, but I believe that quicker rehabilitation would make such an endeavor a good investment for the community at large.

JOSEPH NEUFELD, A.I.A.
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IT SEEMS less important to discuss the detailed pros and cons of this particular plan than to urge all hospital administrators to consider earnestly how to state their particular philosophy of care and its program in this same manner. Only in this way can an architect develop an effective solution as Mr. Izumi has done.

So far as detail is concerned—scheme D (24 beds) is a bit less open in character than scheme E (20 beds); the closer, splayed walls in D and narrower openings into core area may create a desirable sense of protective enclosure for small group areas. A series of varied ceiling heights would be desirable—the large diameter core should be considerably higher spaced to give an important sense of expansion as persons emerge from more personal into group activities. This can be supplemented by visual expansion into the landscaped area, which preferably should not be closed in but have a vista so the eyes can rest on relative distance. Daylighting and venting of core should be supplemented by clerestory windows in spite of increased heat loss—one-sided lighting creates distressing glare. The core should also have effective acoustic treatment.

I am certain that it would be important to add another exit at the opposite side of each core. A fire at the only exit (which is next to kitchen and laundry in scheme D) even with only 24 occupants, could pile up traffic.

As noted in point 9 of Dr. Osmond's paper, each "retreat" should permit its occupant to express his personality in its decor. Especially should the entrance to the small group area be distinctive so that no patient need be confused about which one leads to his room. These small group areas do much to break down institutional conformity.

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Staff Executive, Committee on Hospitals and Health
American Institute of Architects
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IT HAS BEEN a pleasure to review Dr. Humphry Osmond's concise, interesting and extremely readable article. I have felt that this is so important that I have reproduced it and given copies to about twenty of my associates, so you can consider this a corporate comment of Sherlock, Smith and Adams.

It was our feeling without exception that Dr. Osmond's piece was one of the finest articles we have been privileged to read. His writing is fine and clear, and his reasoning appears to be exceptionally sound. We feel that for the first time we are actually getting an understanding of the problem and are beginning to feel related to the people involved. His presentation of the characteristics of the psychotic brings us closer than we have been able to come before to the kind of information needed in order to design intelligently for mental patients.

As a matter of general comment on the text, although we realize that Dr. Osmond's paper is not supposed to be a full coverage, we feel that the architect could be of further help if the group activities now devised were more fully described.

With regard to organization, it would seem worthwhile to title the paragraphs on pages four and five: A. SIGHT B. HEARING C. TIME E. SMELL and F. MOOD. To carry this point further, we wonder if the five senses should not be grouped together, followed by "TIME" and "MOOD." It may be a matter of semantics, but the paragraph on "perception, thinking and feeling . . ." seems a bit confusing. To us, perception is accomplished through the five senses, with thinking and feeling distinguished from them.

In reviewing this article, we have done a bit of re-evaluation of the architect's position in the task of mental hospital planning. We are fully cognizant of our deficiency of knowledge in this field of research and treatment; we are also aware that architecture is an *aid* and not a solution. The physical facilities, though important, are infinitely less so than the quality of the psychiatry practiced in any hospital. It is operation, maintenance, medical practice which make the psychiatric hospital—or any hospital—good or bad in the basic sense. Dr. Paul Haun, in a talk to the Architectural Study Project Consultant's Committee, expressed this as "gestures of love on the part of the staff toward the patient." Our profession has its share in these gestures of love; although it cannot make them directly, it can help or hinder the efforts of those who administer the hospital, diagnose ills, and care for the patient. Our responsibility is to make the staff's gestures of love feasible, and more effective wherever possible. The greater the simplicity with which the task is stated, the more likely architecture is to fulfill this responsibility. Dr. Osmond's awareness of these capabilities and responsibilities of architects, as well as their limitations, is exceedingly encouraging.

In connection with this conception of architecture as an aid to the therapeutic effectiveness of the hospital, we have felt it worthwhile to organize Dr. Osmond's material on "Rules Deriving from the Patient's Needs" into the general classifications of "Static" and "Continuous," conceiving of the "static" elements as those which are irrevocably established, and the "con-

tinuous" as those which can be effected, modified, or changed at any time. This has resulted in an outline of "Needs" in what seems to us a logical progression:

1. Sufficient Space ("Patients must not be overcrowded") –Static

2. Limited Concentration ("Patients must not be overconcentrated") –Static

3. Path of Retreat ("The provision of a path of retreat") –Static

4. Private Place ("Need for private place") –Static

5. Preservation of Personality and Individuality–Static and Continuous

6. Reduction of Ambiguity and Uncertainty–Static and Continuous

7. Sexual de-segregation ("Note on the Sexual Segregation of Patients") Static and Continuous

8. Consideration of Psycho-Social Needs ("Psycho-Social Needs Must be Met") Static and Continuous

9. Preservation and Limitation of Choice–Continuous

10. Beneficial Relations – Continuous

In this sort of organization, the elements considered "static" are those which we feel come particularly within the province of the architect, while the effectiveness of the "continuous" aspects are primarily dependent upon the medical practices of the hospital. We believe that in many ways the success of the "continuous" features is contingent upon the "statics," and that the position of architecture as an aid to psychiatric practice is thus more clearly delineated.

We have given as much thought as time would permit to the plan solutions proposed by Mr. Izumi. His work shows an astute analytical mind, well-trained, and a burning desire to be of service. Certainly all of these are prerequisites for an architect to make progress. We question the validity of one architect's criticizing, even constructively, another architect's work. There is a bit of the "prima donna" in each of us; we never get away from the feeling, even with our own work, that we could have done it better. Therefore, what we have to say is not to be construed as disparagement of Mr. Izumi's solution, but only as another angle of approach. We hope that it will be as worthy in stimulating further thought.

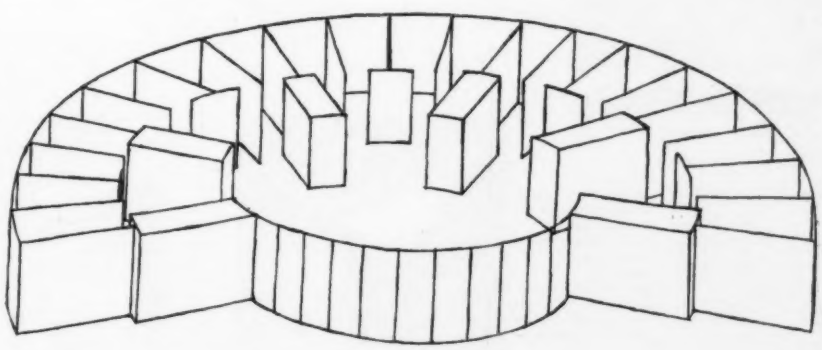
The basic problem as stated, to meet the patient's needs in developing from the purely personal perimeter to that involving a limited number of people, to that involving an unlimited number, is well delineated. We agree with Dr. Osmond's thesis that "structure will determine function, unless function determines structure." This fact makes the architects' task to devise a structural expression of the functional requirements which have been outlined. Thus it is imperative that the architect understand the desired function, so that a structure based on misunderstanding of function will not distort the effectiveness of the hospital. However, we feel that Mr. Izumi's solutions, while extremely fine as a "schematic," or "organization chart," to show relationships of various areas, persons and activities, do not seem to fulfill the requirements of the individual patient as set forth by Dr. Osmond.

Disadvantages Noted

We will attempt first to describe these disadvantages as they appear to us. Our immediate, and strongest, reaction to the circular or semi-circular plan development is that the obviously unfamiliar shapes resulting from the wedge-shaped perimeter areas, as well as the circular space itself, seem contradictory to Dr. Osmond's contention that familiar shapes and surroundings should be afforded wherever possible. In connection with the comments about visual changes in schizophrenics, we question the advisability of triangular or trapezoidal spaces in which the feeling of false perspective would probably make a well person wonder at times about the validity of his senses. Much is said about the need for reassurance and for a feeling of security, and it is our conviction that the room shapes resulting from this plan solution would be most unsuitable from this standpoint.

The round area leaves us with a number of questions. The circle is the most rigid of all geometric forms; as a shape, it forces itself upon us and tends to force the eye to one central point, eliminating the element of choice which Dr. Osmond so strongly advocates. A person in a circular area would very possibly tend to gravitate to the center or else to hug the periphery. Moreover, the circle implies motion, which could well be distressing to a mind groping for repose or security. Nothing is so endless as a circle, except a sphere. The sense of false perspective in a circular, or particularly in a hemispherical, area is most disturbing to the normal vision; we would ask if the answer to distorted sense of perspective is to do away with perspective altogether. Again, the need for familiar surroundings makes us dubious about the circular form. Once an alcoholic friend who was coming out of a stupor said: "Someday I will have a circular room!" Perhaps this could really be what is needed; however, this circle, being "cut up like a pie," does not result in circular rooms, but in a series of "no shapes." At any rate, even though we live in a circular world, we question whether we want to be cooped up in buildings with a circular form so that we daily and hourly "go around in circles."

The perspective sketch (below) is our attempt to give some impression of the disturbing result of seeing in one line of vision, a circle, a trapezoid, and a series of almost–but not quite –rectangular spaces.



Another comment on Mr. Izumi's solution, plan-wise, is that while it diagrammatically achieves the individual–small group–unlimited group relationship, it appears to defeat the purpose of privacy in that it opens all rooms into each other, thereby disregarding the idea of retreat and making it necessary for a patient in the large area of recreation to pass through the more intimate group before he can get to the privacy of his room.

We believe that the circular plan is poor from an acoustical standpoint, causing auditory peculiarities which Dr. Osmond feels should be avoided for the mentally ill. This could be corrected, of course, by acoustical treatment; but we mention it as a further disadvantage of the proposed solution.

We also wonder if the grouping of patients into four in such an inflexible way is advisable. It seems that provision for grouping two, three, four or five persons might be preferable; it would seem difficult to locate invariably four patients who would be sufficiently congenial for the intermediary "small group" area to have real therapeutic value.

The visitors' areas, we believe, should be of a more conventional shape and provide greater privacy for patients' visits with family and friends.

Progressing now to a few positive suggestions which have occurred to us in connection with the material reviewed, the notes on the visual perception of schizophrenics have led us to wonder if it would be feasible to construct a "laboratory" room, where light intensity with full color range variables, as well as space variables, could be utilized for reaction studies. If this were done with automatic registration of pulse, heart, muscular tension, etc., we believe we could relate our findings to architecture for psychiatric hospitals. Since the reactions of the psychotic are not the same as those of well persons, could it be possible that we might find, for example, that red was restful to the psychotic rather than exciting? Perhaps all of the senses need analysis to see what the changes in thinking and feeling of the psychotic actually are, and how they can be utilized to aid in his reorientation.

Unless the results of such experimentation indicate differently, we would make positive recommendations somewhat as follows. We believe that while it seems inevitable in any institutional plan that there will be a sameness of individual rooms, it is possible to use room colors, finishes, fabrics, etc., to indicate individuality a great deal more advantageously than has customarily been done.

To enable each person to express his individuality in tastes, we would recommend a picture and sculpture library, providing art both for the patient to look at in the library, and to borrow and exchange as he wishes, affording a further means of personality preservation for him.

Along with this element of choice in room finishes, pictures, etc., we feel it strongly advisable to provide chapels in this scheme (see schematic plan, at left), giving the patient another important choice in the matter of religion.

We are strongly in favor of provision for outdoor-indoor living. Small and large courts, passages opening into courts, cloisters, private, semi-private and open outdoor spaces, seem to us essential in any planning of this sort.

Our own thinking is that a small, unpretentious community of buildings, possibly connected by passages opening into courts, would achieve the desired results of producing a familiar and reassuring living situation, affording tranquillity and repose–both in private rooms and in the outdoor areas–preserving the patient's sense of individuality through differences in room treatment, and encouraging re-establishment and re-development of beneficial interpersonal relationships.

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Sherlock, Smith & Adams
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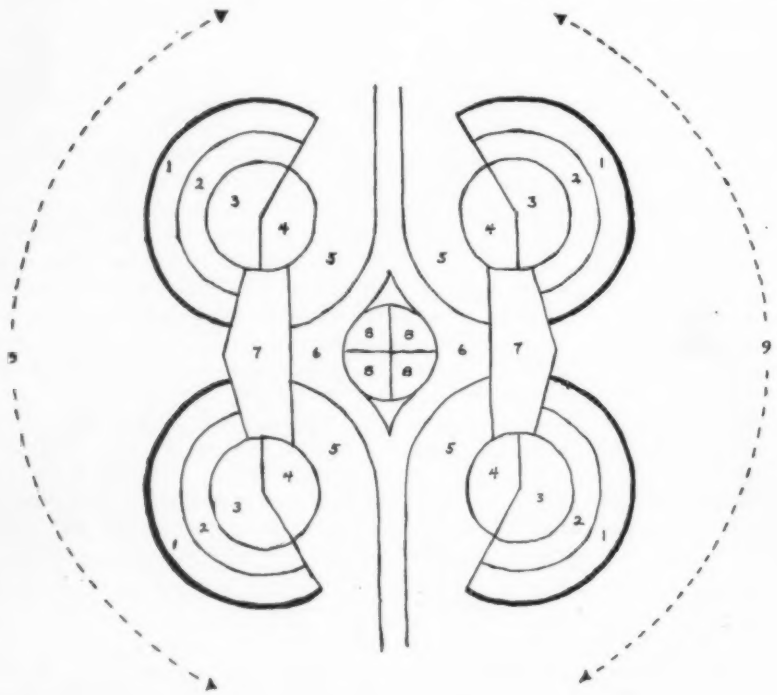

LEGEND
1. RETREAT
2. SMALL GROUP AREA
3. LARGE GROUP AREA (INDOOR)
4. LARGE GROUP AREA (OUTDOOR)
5. HIGHLY DEVELOPED PLANTING
6. COVERED WALK
7. CORE
8. MEDITATION CHAPELS
9. NATURALISTIC LANDSCAPE FOR VIEW FROM RETREAT. CAN BE USED FOR SOLITARY STROLLING.

NOTE:
WE ARE USING CIRCLES SCHEMATICALLY.